April 6, 2011

Ladies and Gentlemen:

Most Texans know that our state government faces significant financial challenges today. As Comptroller, it's my duty to watch trends that affect our bottom line. One of the most important forces driving the current fiscal crunch is the spiraling cost of health care services.

As a contribution toward understanding and exploring this pressing issue, I hope you will find our new report, *State Health Care Spendin*g, a helpful resource.

In fiscal 2009, more than 50 Texas state agencies spent more than **$30 billion** in state, federal and other funds on health care, including Medicaid payments, mental health services, employee health insurance and health care for prisoners. That's more than a third of all state spending. These costs are mounting at an alarming rate.

In the five years between fiscal 2005 and 2009, Texas' health care costs leaped by 36.1 percent — nearly four times as fast as the inflation rate, and more than *four times* as fast as the state's population growth.

This report examines the factors behind this surge, examining expenditures by agency and identifying major cost drivers for each. The report also provides recommendations that could help the state begin to address these skyrocketing costs.

By taking steps now, we can more effectively contain rising costs while maintaining vital health care services for all Texans.

Sincerely,

Susan Combs

WWW.WINDOW.STATE.TX.US • P.O. BOX 13528 • AUSTIN, TX 78711-3528 • 512-463-4000 • TOLL FREE: 1-800-531-5441 • FAX: 512-463-4965

**To view the endnotes and appendices for this study, please visit**

**www.window.state.tx.us/specialrpt/healthcare/**

The **Endnotes** show detailed information about the sources used in the report. **Appendix I** contains the definition of health care as used in this report; **Appendix II** is a detailed examination of health care expenditures by agency; and **Appendix III** contains information regarding regional variations in state health services costs, comparing Medicaid, Employees Retirement System of Texas and BlueCross BlueShield of Texas services.

# Table of Contents

# State Health Care Spending

*In fiscal 2009, more than 50 state agencies and higher education institutions spent about* **$30.2 billion** *on direct health care.*

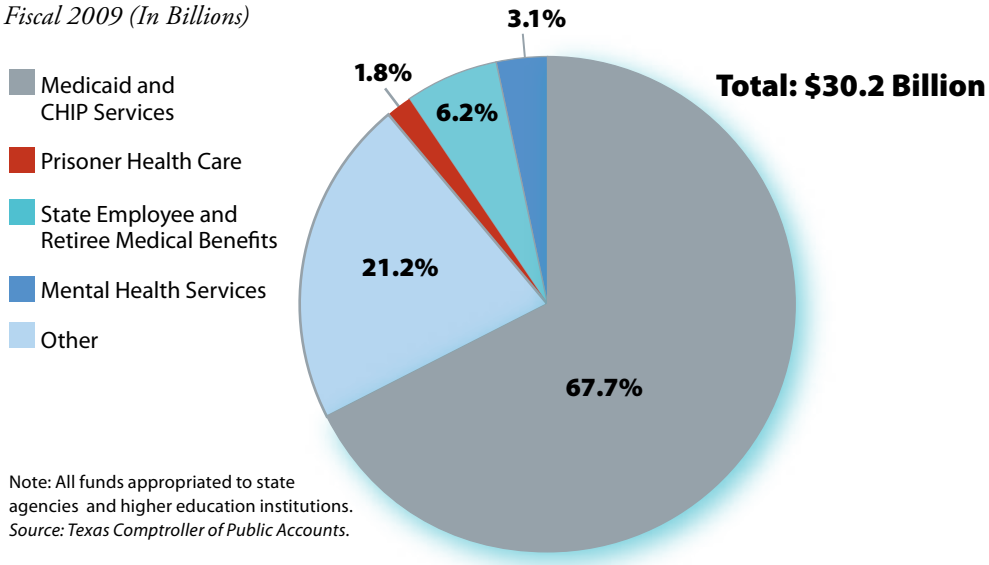
## OVERVIEW

Health care accounts for more than 34 percent of all Texas government spending from state, federal and other sources. In fiscal 2009, more than 50 state agencies and higher education institutions spent about **$30.2 billion** on direct health care such as Medicaid for the poor, disabled and elderly; community and institutional mental health services; medical benefits for state employees and retirees; and health care for prisoners **(Exhibit 1)**.

EXHIBIT 1

**TEXAS HEALTH CARE EXPENDITURES**

*Fiscal 2009 (In Billions)*




Note: All funds appropriated to state agencies and higher education institutions.
*Source: Texas Comptroller of Public Accounts.*

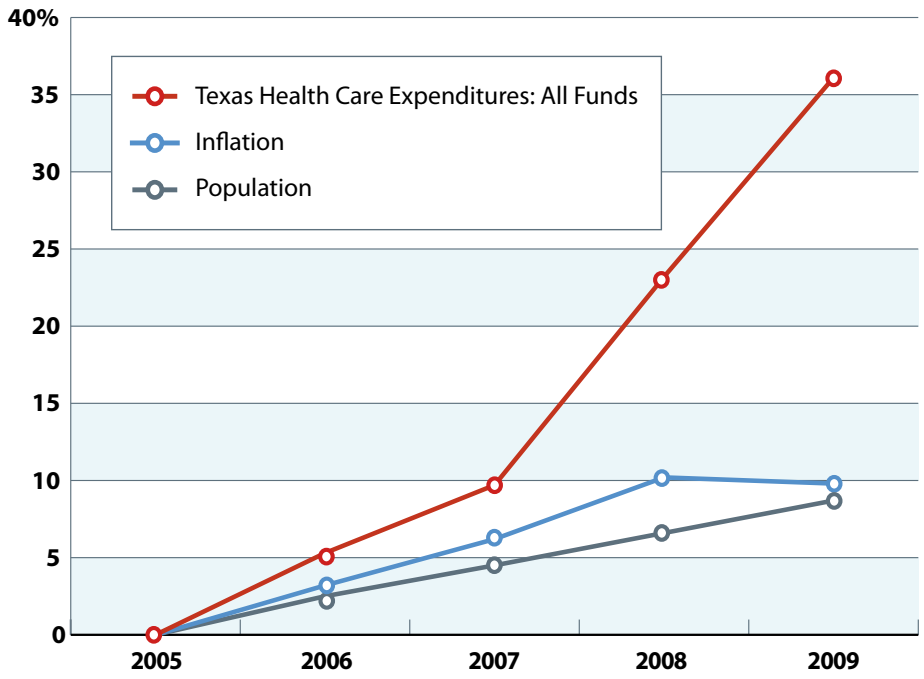
- The fiscal 2009 total of $30.2 billion represented a **36.1 percent** increase from fiscal 2005.
- By contrast, inflation for these years totaled **9.8 percent**, while the state's population rose by **8.7 percent (Exhibit 2)**.[1]

**Exhibit 3** lists the state agencies and higher education institutions that constitute the state's health care "footprint" and their fiscal 2009 expenditures arranged by General Appropriations article. (For the definition of "health care" as used in this report, please refer to Appendix I. For detailed health care expenditures by agency, please refer to Appendix II. The appendices to this report can be found at http://www.window.state.tx.us/specialrpt/healthcare/.)

EXHIBIT 2

**GROWTH IN TEXAS HEALTH CARE EXPENDITURES VS. GROWTH IN POPULATION AND INFLATION**

*Fiscal 2005 through 2009*




*Sources: Various state agencies, U.S. Census Bureau and U.S. Bureau of Labor Statistics; calculations performed by Texas Comptroller of Public Accounts.*

EXHIBIT 3

## TEXAS HEALTH CARE EXPENDITURES, ALL FUNDS AND GENERAL REVENUE, BY ARTICLE

*Fiscal 2009 (Amounts in Millions)*

| | ALL FUNDS | GENERAL REVENUE |
|---|---|---|
| **Article I-General Government Agencies** | | |
| Employees Retirement System | $1,199.0 | $786.3 |
| State Office of Risk Management | 50.7 | 43.1 |
| **Article II-Health & Human Services Agencies** | | |
| Health and Human Services Commission | 17,460.7 | 5,765.8 |
| Department of Aging and Disability Services | 5,886.0 | 1,852.3 |
| Department of State Health Services | 1,766.8 | 1,105.8 |
| Department of Assistive and Rehabilitative Services | 135.8 | 40.7 |
| Department of Family Protective Services | 1.9 | 1.1 |
| **Article III-Education Agencies** | | |
| Teacher Retirement System | 267.6 | 267.6 |
| Texas Education Agency | 228.6 | 228.6 |
| Texas School for the Deaf | 3.3 | 3.3 |
| Texas School for the Blind and Visually Impaired | 4.6 | 4.4 |
| University of Texas | 298.2 | 196.4 |
| Workers' Compensation | 4.8 | 3.4 |
| Texas A&M University | 101.7 | 94.7 |
| Workers' Compensation | 3.1 | 2.7 |
| Health-Related Institutions of Higher Education | 1,932.1 | 334.7 |
| Health-Related Research at Higher Education Institutions | 272.4 | 272.4 |
| **Article V-Public Safety and Criminal Justice Agencies** | | |
| Texas Department of Criminal Justice | 547.8 | 538.0 |
| Texas Youth Commission | 19.9 | 19.9 |
| Texas Juvenile Probation Commission | 1.9 | 1.9 |
| **Article VII-Business and Economic Development Agencies** | | |
| Texas Department of Transportation<br>Workers' Compensation | 5.8 | 5.8 |
| Texas Department of Rural Affairs | 2.2 | 2.2 |
| **Total Health Care Expenditures** | **$30,194.9** | **$11,571.3** |

Note: Expended amounts represent funds that were appropriated through the General Appropriations Act.

*Source: Texas Comptroller of Public Accounts.*

*Health care spending from general revenue totaled* **$11.6 billion** *in fiscal 2009.*

## GENERAL REVENUE

Health care spending funded by the state's General Revenue Fund is particularly significant to the state budget because general revenue is the primary source of revenue over which the state's budget writers have discretionary control.

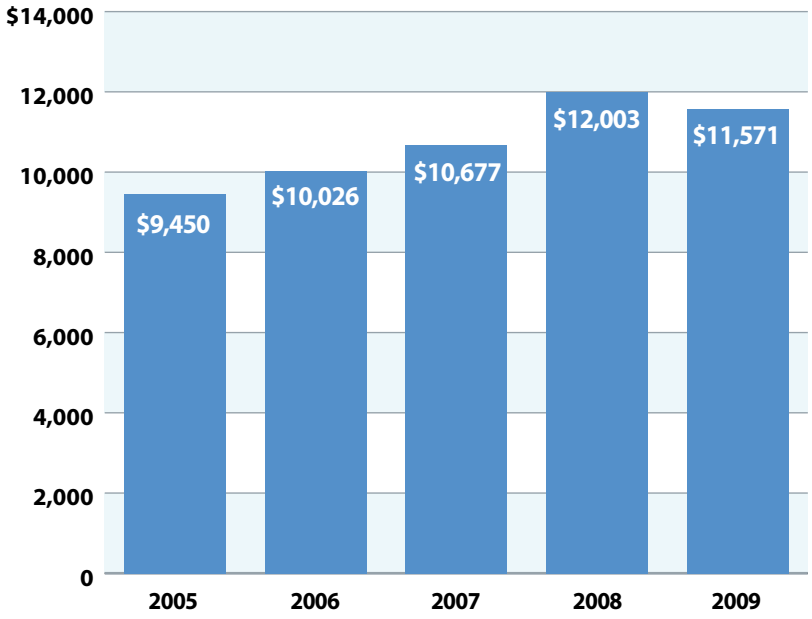
- Health care spending from general revenue has risen steadily, increasing **22.3 percent** since 2005 **(Exhibit 4)**. In fiscal 2009, it totaled **$11.6 billion**, accounting for nearly 27 percent of all general revenue appropriations.
- General revenue spending fell slightly in fiscal 2009 due to additional federal funding for Medicaid made available through the federal "stimulus" legislation. Since that funding was temporary, general revenue spending on Medicaid is expected to resume its upward climb.
- Recent federal health care reform legislation may make state spending on health care grow even faster. (For more on that legislation and its impact on Texas, please see the Comptroller's 2010 report, *Diagnosis: Cost –An Initial Look at the Federal Health Care Legislation's Impact on Texas,* at http://www.window.state.tx.us/specialrpt/healthFed/.)

*Health care spending from general revenue has risen steadily, increasing* **22.3 percent** *since 2005.*

EXHIBIT 4

### TEXAS HEALTH CARE EXPENDITURES FROM GENERAL REVENUE

*Fiscal 2005 through 2009 (In Millions)*




Note: Figures represent expenditures funded through both General Revenue and General Revenue-Dedicated funds.

*Source: Texas Comptroller of Public Accounts.*

## PURPOSE OF THIS REPORT

The 2011 Texas Legislature faces the difficult task of creating a budget that allows state agencies to deliver critical services to Texans without exceeding expected state revenues, which are still recovering from the recent recession.

Since health care represents such a substantial portion of the state budget, it is inevitable that lawmakers will seek ways to rein in costs and deliver services more efficiently. Toward that end, this report examines the largest categories of health care expenditures made by state agencies and identifies the major cost drivers for each. These data, in turn, were used to develop a targeted list of proposals addressing the areas of greatest concern.

*This report examines the largest categories of health care expenditures made by state agencies and identifies the major cost drivers for each.*

## STATE EXPENDITURES

Five Texas state agencies accounted for 89 percent of all health care spending and 87 percent of general revenue health care spending in fiscal 2009 **(Exhibits 5 and 6)**:[2]

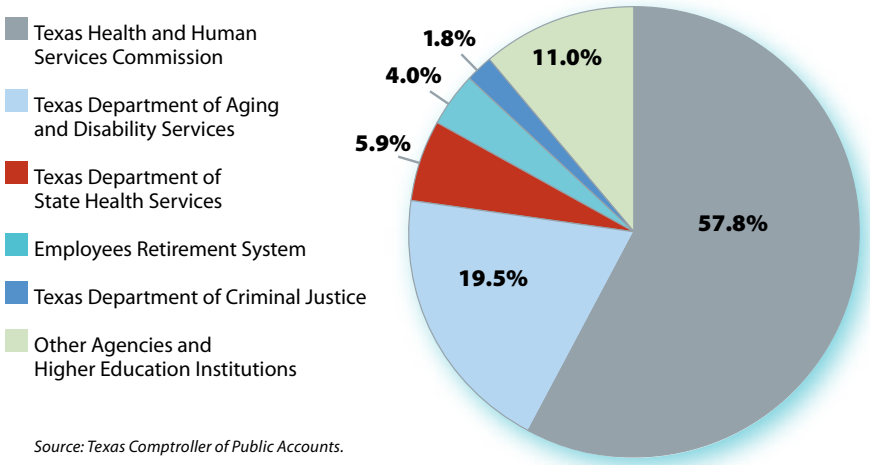
**1.** Texas Health and Human Services Commission (HHSC)
**2.** Texas Department of Aging and Disability Services (DADS)
**3.** Texas Department of State Health Services (DSHS)
**4.** Employee Retirement System (ERS)
**5.** Texas Department of Criminal Justice (TDCJ)

*Five Texas state agencies accounted for* **89 percent** *of all health care spending in fiscal 2009.*

EXHIBIT 5

### SHARE OF ALL HEALTH CARE SPENDING

*Fiscal 2009*

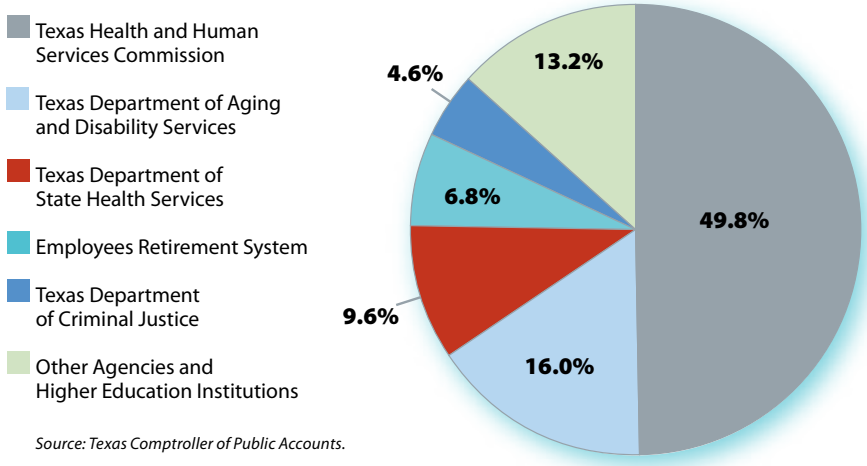



*Source: Texas Comptroller of Public Accounts.*

EXHIBIT 6

### SHARE OF GENERAL REVENUE HEALTH CARE SPENDING

*Fiscal 2009*




*Source: Texas Comptroller of Public Accounts.*

### HHSC AND DADS: MEDICAID

Nearly all of the health care spending of the top two agencies, HHSC and DADS, is for Medicaid, a state-administered federal program that provides medical care to eligible low-income individuals, families, the elderly and people with disabilities.

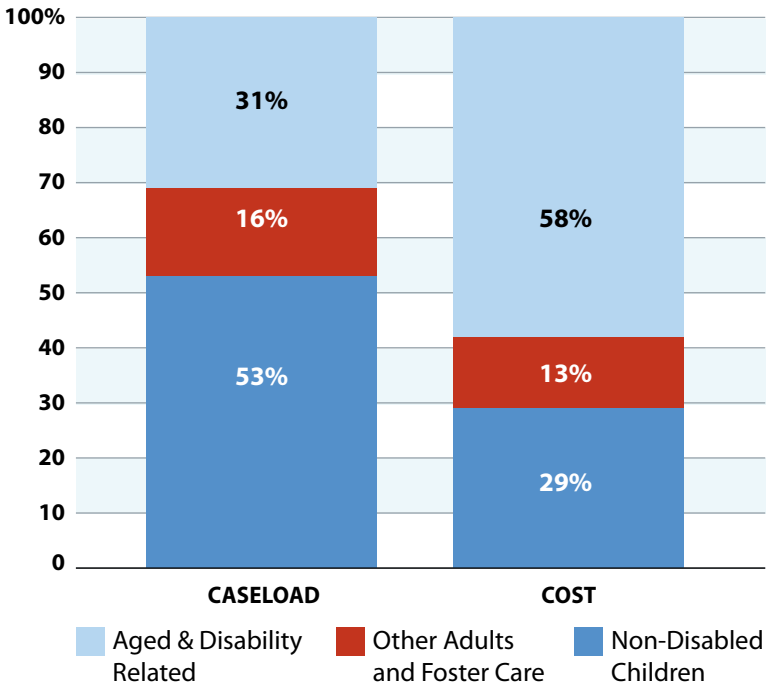
- In fiscal 2009, Texas spent more than **$23.3 billion** in all funds on Medicaid and the Children's Health Insurance Program (CHIP); more than 95 percent of this amount was spent on Medicaid.
- General revenue and general revenue-dedicated Medicaid spending totaled **$7.6 billion**.
- The average Medicaid per-member monthly cost for acute and long-term care was **$519**.[3]
- Non-disabled children make up most of the Medicaid population, accounting for about 53 percent of all beneficiaries, but represented only 29 percent of all Medicaid spending on direct health care services in fiscal 2009.[4]
- The aged, blind and disabled accounted for 31 percent of Texas' Medicaid clients, but were responsible for 58 percent of the program's expenditures **(Exhibit 7)**.[5]

*General revenue and general revenue-dedicated Medicaid spending totaled* **$7.6 billion.**

EXHIBIT 7

**TEXAS MEDICAID BENEFICIARIES AND EXPENDITURES**

*Fiscal 2009*




*Source: Texas Health and Human Services Commission and Texas Comptroller of Public Accounts.*

*In fiscal 2009, 77 percent or* **$13.5 billion** *of HHSC's health care expenditures supported acute care services for Medicaid clients.*

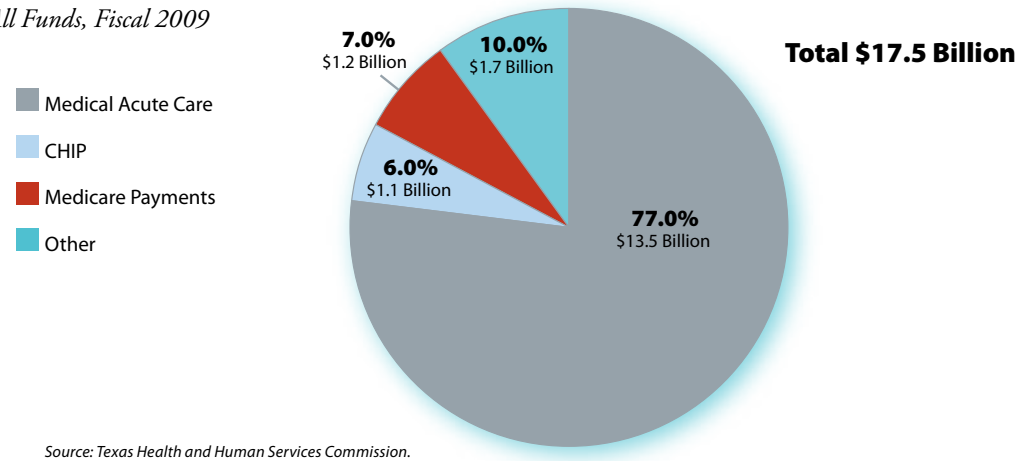
- In fiscal 2009, 77 percent or **$13.5 billion** of HHSC's health care expenditures supported **acute care services for Medicaid** clients. Acute care — including hospital and physician services, prescription drugs and laboratory services — is delivered primarily to low-income children and their families.
- The remaining health care expenditures at HHSC include **$1.1 billion** for CHIP; **$1.2 billion** in Medicare payments for dual-eligible clients; and **$1.7 billion** in other expenditures, primarily indirect and administrative support **(Exhibit 8)**.

HHSC's health care spending rose by **46 percent** from fiscal 2005 to 2009; during the same period, the Medicaid acute-care caseload grew by 12.5 percent and inflation rose by 9.8 percent **(Exhibit 9)**.

EXHIBIT 8

**TEXAS HEALTH AND HUMAN SERVICES COMMISSION HEALTH CARE SPENDING**

*All Funds, Fiscal 2009*

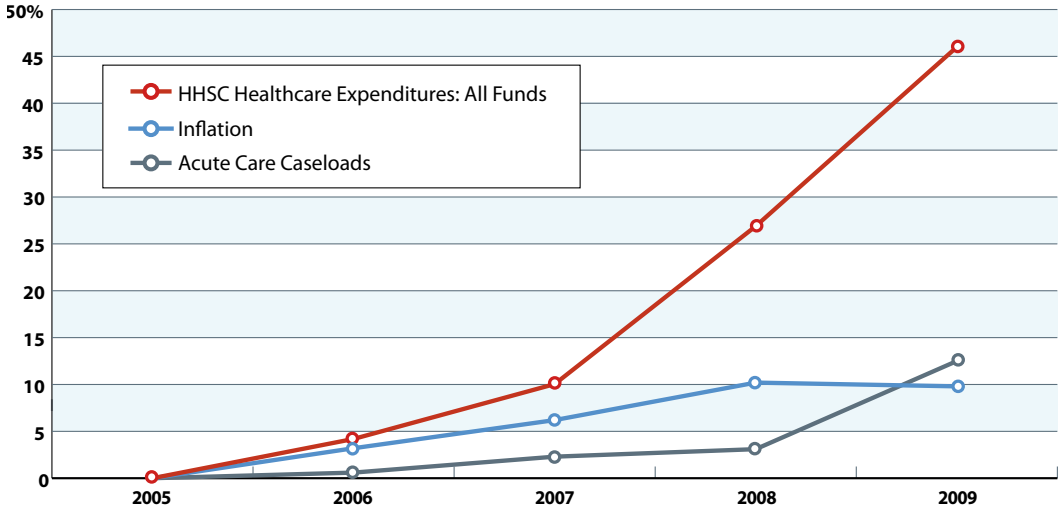



*Source: Texas Health and Human Services Commission.*

EXHIBIT 9

**GROWTH IN HEALTH CARE EXPENDITURES AT HEALTH AND HUMAN SERVICES COMMISSION VS. GROWTH IN MEDICAID ACUTE CARE CASELOAD AND INFLATION**

*Fiscal 2005 through 2009*




*Sources: Texas Health and Human Services Commission, U.S. Census Bureau and U.S. Bureau of Labor Statistics; calculations performed by Texas Comptroller of Public Accounts.*

By contrast, from fiscal 2005 to 2009 nationwide Medicare spending and private health insurance spending rose by **47.8 percent** and **14.9 percent**, respectively.[6]

HHSC delivers Medicaid benefits through three primary delivery models:

- **Primary Care Case Management** (PCCM) uses primary-care physicians (PCPs) to coordinate preventive and primary-care services and authorize referrals to specialists. PCPs receive a monthly case management fee for each client served and a fee for each service delivered.
- the state contracts with **health maintenance organizations** (HMOs) to provide services to certain beneficiaries, paying a monthly premium for each person enrolled.
  - ***STAR HMO*** operates through HMOs in nine Texas urban areas. The program provides uniform monthly payments per client to managed care organizations to cover the cost of the services they provide.
  - ***STAR+PLUS*** serves clients with chronic and complex conditions and operates in areas surrounding Bexar, Harris, Nueces and Travis counties. STAR+PLUS carves out from the monthly fee the cost of inpatient hospital services, which are paid through a traditional fee-for-service arrangement.
  - ***STAR Health*** is a statewide managed care program serving children and youth in foster care and kinship care.
- **fee-for-service providers** receive reimbursements for services provided. These arrangements are primarily for episodic services not included under managed care plans.[7]

## Increased Utilization

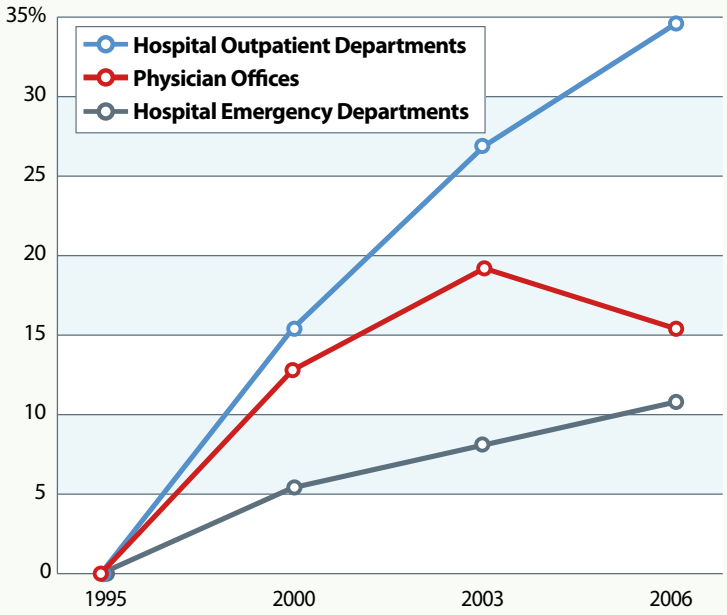
Americans today tend to see doctors more frequently than they did in the past.

+ According to CDC, U.S. physician office visits per 100 persons rose from **266** to **307** between 1995 and 2006, an increase of **15.4 percent**.
+ Hospital outpatient visits rose by **34.6 percent** during the same period, from **26** to **35** visits per 100 persons.
+ Emergency room visitation rates also increased, but to a lesser extent, rising from **37** visits per 100 persons in 1995 to **41** in 2006 .[8]

**VISITS TO PHYSICIAN OFFICES, HOSPITAL OUTPATIENT DEPARTMENTS AND HOSPITAL EMERGENCY DEPARTMENTS**

*1995-2006*

**1995-2006**




*Source: Centers for Disease Control and Prevention*

## Texas Health Insurance Risk Pool

The Texas Health Insurance Pool is the **insurer of last resort** for Texans under 65 who cannot obtain health insurance coverage due to preexisting medical conditions. It also guarantees access to health insurance for Texans who lose group coverage, such as those who are laid off. [9]

- Eligible persons can choose from **one of five insurance plans** with a maximum lifetime benefit amount of $3 million.
- Premiums are set as a **percentage of the average rate** Texas insurers charge for comparable coverage. Since 2004, this has been at the legal maximum of **200 percent**.
- In 2009, the pool's average monthly premium was **$620**, up **4.6 percent** from 2008.[10]
- In addition to member premiums, the pool levies an **assessment on health insurers** to cover its costs. The pool receives **no state funding** and insurers receive no tax credit for their assessment payments.[11]
- In 2009, the pool paid **$273.3 million** in benefits and **$12.8 million** in operating expenses, including administrative costs and professional and agent referral fees, and collected **$198.6 million** in premiums and **$77 million** in assessments, as well as **$10.5 million** in federal grants.
- At the close of 2009, the pool insured **26,556 members**.[12]

### FEDERAL LEGISLATION

The Patient Protection and Affordable Care Act of 2010 will have **immediate effects** on the Texas Health Insurance Risk Pool.

- The act will cover individuals who have been without insurance for six months and have a preexisting condition. It will provide this coverage until **2014**, when individuals can no longer be denied coverage based on their health.
- Coverage through the federal program began on **August 1, 2010**. Eligibility will be limited to U.S. citizens or legal residents who:
  - had no health insurance for six months prior to applying for federal coverage; and
  - have a preexisting medical condition as determined by the U.S. Department of Health and Human Services. [13]

Persons covered by the Texas Health Insurance Pool **will not be eligible to participate** in this program because they do not meet the requirement of having been uninsured for six months.

In fiscal 2009, fee-for-service arrangements accounted for **29.2 percent** of Texas Medicaid's acute-care caseload, but **48 percent** of its acute-care expenditures **(Exhibit 10)**.

EXHIBIT 10

**TEXAS MEDICAID ACUTE CARE BREAKDOWN OF EXPENDITURES BY SERVICE DELIVERY TYPE**

*Fiscal 2009*

| | PERCENT OF CASELOAD | PERCENT OF EXPENDITURES | COST PER MEMBER, PER MONTH |
|---|---|---|---|
| **PCCM** | 25.5% | 16% | $230 |
| **HMOs:** | | | |
| STAR HMO | 39.0% | 24% | $221 |
| | 5.3% | 10% | $644 |
| STAR Health | 1.0% | 2% | $643 |
| **Fee-for-Service** | 29.2% | 48% | $315 |
| **Total** | **100.0%** | **100%** | **$277** |

Note: Does not include long-term services and support, vendor drug or dental care.

*Source: Texas Health and Human Services Commission.*

- HHSC estimates that expanding the areas covered by STAR and STAR+PLUS managed care plans would result in state savings of more than **$348 million** in general revenue for the 2012-13 biennium.
- The Medicaid managed care model provides increased quality by coordinating patient care through HMOs, which ensures that patient needs are met through contracted provider networks offering both general and specialty medical care. HMOs perform medical necessity audits, require preauthorization of services and reduce unnecessary medical services utilization.
- In addition to cost savings, the state could realize an estimated gain in insurance premium tax payments of **$168 million** for the 2012-13 biennium from HMOs due to increased revenues.[14]

DADS administers **Medicaid long-term care** through both community and institutional settings for the elderly and the disabled, including residential services for the people with intellectual disabilities in its State Supported Living Centers (formerly called state schools).

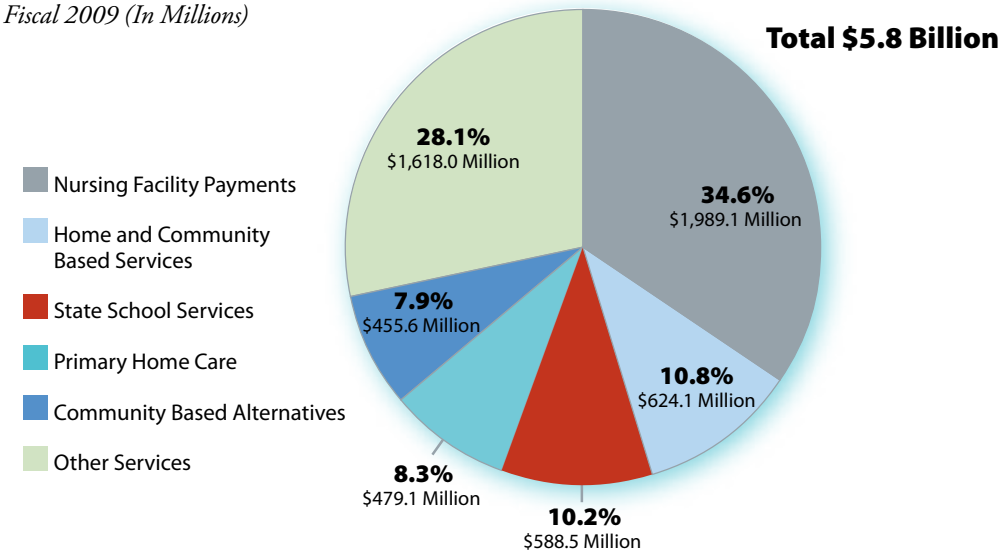
- In fiscal 2009, DADS spent **$5.8 billion** on long-term care activities, such as assisting clients with daily needs, providing employment services, paying for home improvements and paying for nursing home and hospice care **(Exhibit 11)**.
- Payments to nursing facilities represented 34.6 percent of DADS' spending on long-term care, making it the largest single expenditure category.
- Home and community-based services that occur in an individual's own home or in a foster/companion care setting represented 10.8 percent of long-term care spending.
- Services provided at state schools accounted for 10.2 percent.
- Primary home care services to assist individuals in daily tasks represented 8.3 percent.

*DADS administers* **Medicaid long-term care** *through both community and institutional settings for the elderly and the disabled.*

EXHIBIT 11

**TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES**
**SPENDING FOR MEDICAID LONG-TERM CARE SERVICES, ALL FUNDS**

*Fiscal 2009 (In Millions)*



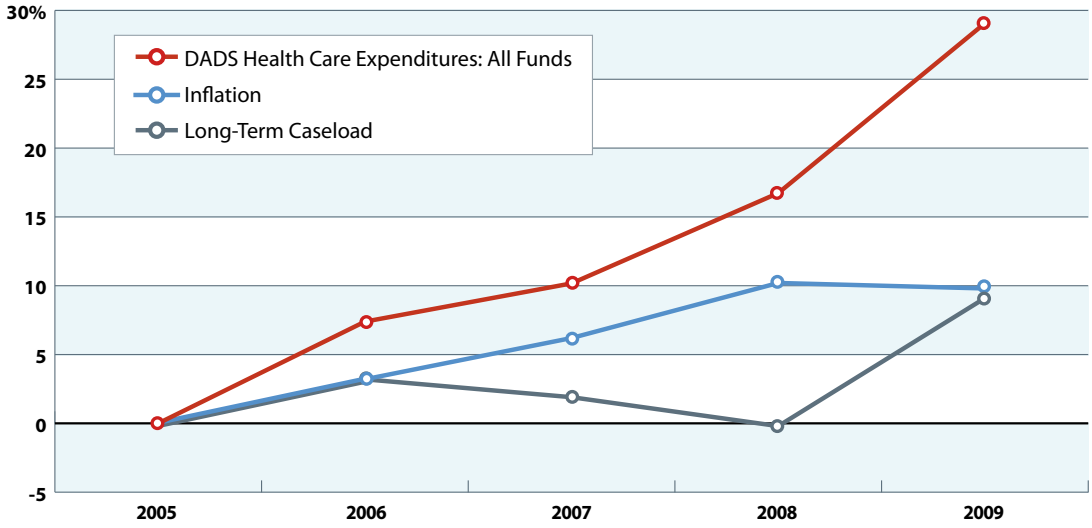

*Sources: Texas Department of Aging and Disability Services and Texas Comptroller of Public Accounts.*

- Community-based alternatives, which provide services to aged and disabled individuals as an alternative to residing in a nursing facility, accounted for 7.9 percent.
- The "other services" category includes things such as community attendant services for those ineligible for primary home care and intermediate care facilities for individuals with mental disabilities.
- While DADS pays for nursing home, hospice care and state school services in institutional settings, its primary focus is on developing long-term care services in the home and community.[15]
- DADS' health care spending rose by **29.1 percent** from fiscal 2005 to 2009, compared with Medicaid long-term care caseload growth of 9.1 percent and inflation of 9.8 percent during the same period **(Exhibit 12)**.

EXHIBIT 12

**GROWTH IN HEALTH CARE EXPENDITURES AT THE DEPARTMENT OF AGING AND DISABILITY SERVICES VS. GROWTH IN MEDICAID LONG-TERM CARE CASELOAD AND INFLATION**

*Fiscal 2005 through 2009*




*Sources: Texas Department of Aging and Disability Services, U.S. Census Bureau and U.S. Bureau of Labor Statistics; calculations performed by Texas Comptroller of Public Accounts.*

## DSHS: MENTAL HEALTH CARE SERVICES

DSHS manages nearly 5,400 client services and administrative contracts from 157 locations around the state. In fiscal 2009, DSHS' health care expenditures totaled **$1.8 billion**; general revenue and general revenue-dedicated health care spending totaled **$1.1 billion (Exhibit 13)**.[16]

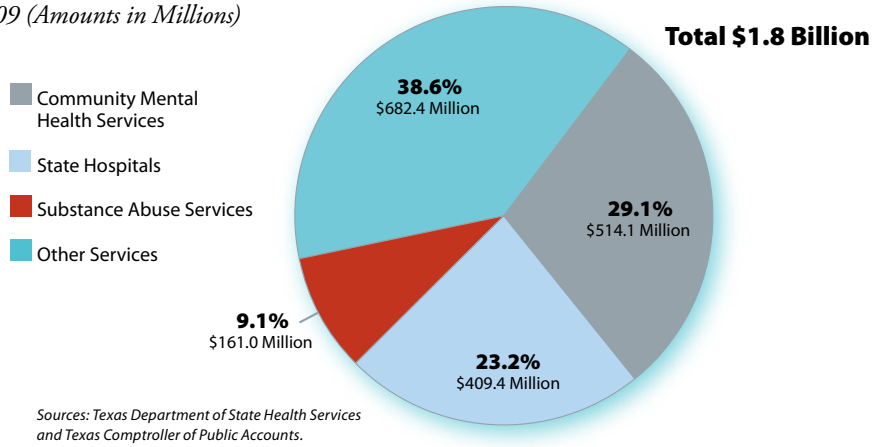
The largest share of DSHS' health care expenses is for **community and institutional mental health services**.

- DSHS provides community-based mental health care services to adults and children through contracts with local mental health authorities, which provide both in-patient and outpatient services including screenings, medication-related services and employment and housing assistance.

EXHIBIT 13

## TEXAS DEPARTMENT OF STATE HEALTH SERVICES SPENDING FROM ALL FUNDS

*Fiscal 2009 (Amounts in Millions)*




*Sources: Texas Department of State Health Services and Texas Comptroller of Public Accounts.*

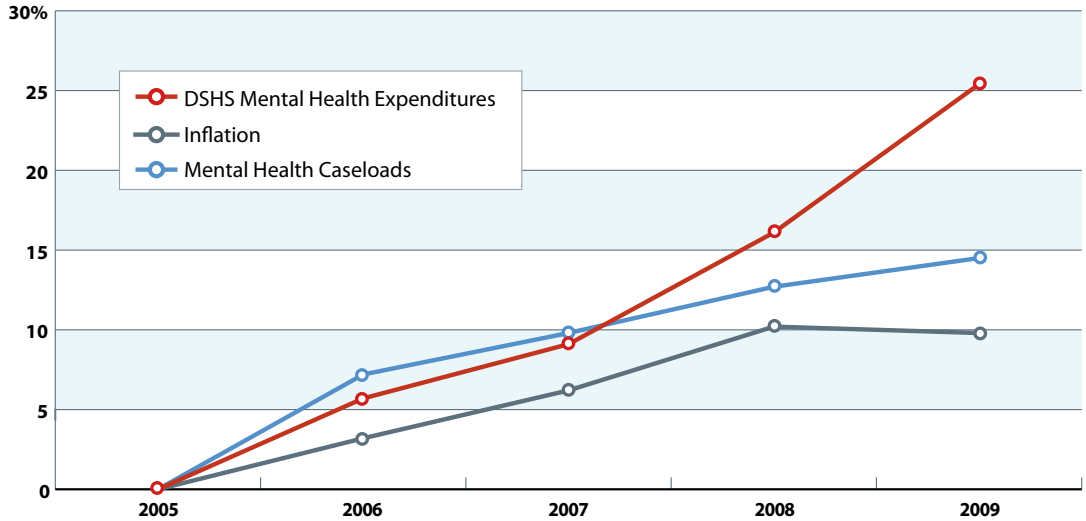
- DSHS operates Texas' eight state mental health hospitals, which provide inpatient hospitalization and general psychiatric services for the mentally ill. These hospitals provide specialized psychiatric services for individuals needing intensive treatment, including short- and long-term care.
- DSHS also administers funding for substance abuse and offers chronic disease and infectious disease programs. It is also responsible for health-related preparedness, prevention and consumer protection activities.
- DSHS' health care spending rose by **26.3 percent** from fiscal 2005 to 2009, compared with mental health caseload growth of 14.5 percent and inflation of 9.8 percent during the same period **(Exhibit 14)**.

*In fiscal 2009, DSHS' health care expenditures totaled* **$1.8 billion**.

EXHIBIT 14

## MENTAL HEALTH EXPENDITURES AT DEPARTMENT OF STATE HEALTH SERVICES VS. MENTAL HEALTH CASELOAD AND INFLATION

*Fiscal 2005 through 2009*




*Sources: Texas Department of State Health Services, U.S. Census Bureau and U.S. Bureau of Labor Statistics; calculations performed by Texas Comptroller of Public Accounts.*

# Indigent Health Care

Texas delivers indigent health care through **hospital districts, public hospitals** and **county indigent health care programs** (CIHCPs). These offer basic health care as well as inpatient, outpatient and nursing facility services.

**Hospital districts** can levy a property tax of up to **80 cents per $100** in property value to fund indigent health care.

State law requires hospital districts to serve persons with incomes below **21 percent** of the federal poverty line; most, however, have established higher income thresholds.

Hospital districts also may receive financing from:

- the state **Tertiary Care Fund** (a pool of unclaimed lottery revenue),
- the federal **Disproportionate Share Hospital Program** (for hospitals that provide a large amount of charity care) and
- the **Graduate Medical Education Program** (supplemental Medicaid and Medicare payments to teaching hospitals).[17]

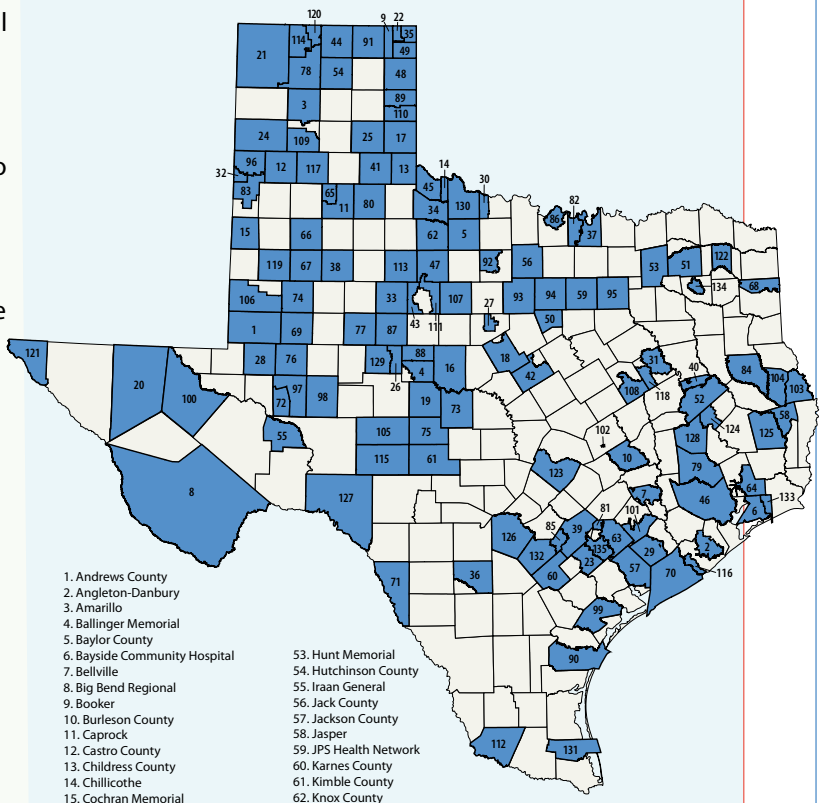
In 2008, Texas' **150 hospital districts** levied **$1.9 billion in property taxes**.

- Harris, Dallas and Tarrant counties and the University Health System in San Antonio, the state's largest hospital districts, accounted for **$1.5 billion** or **79 percent** of the total.

In 2008, the average hospital district tax rate was **19 cents per $100** of assessed property value.

- Rates ranged from **one cent per $100** in the Texhoma (Sherman County), Higgins/Lipscomb (Lipscomb County) and Grapeland (Houston County) districts to **62 cents per $100** in Collingsworth County's Collingsworth General Hospital District. [18]

## TEXAS HOSPITAL DISTRICTS [19]



1. Andrews County
2. Angleton-Danbury
3. Amarillo
4. Ballinger Memorial
5. Baylor County
6. Bayside Community Hospital
7. Bellville
8. Big Bend Regional
9. Booker
10. Burleson County
11. Caprock
12. Castro County
13. Childress County
14. Chillicothe
15. Cochran Memorial
16. Coleman
17. Collingsworth County
18. Comanche County Consolidated
19. Concho County
20. Culberson County
21. Dallam-Hartley Counties
22. Darrouzett
23. De Witt Medical District
24. Deaf Smith County
25. Donley County
26. East Coke County
27. Eastland Memorial
28. Ector County
29. El Campo Memorial Hospital
30. Electra
31. Fairfield
32. Farwell
33. Fisher County
34. Foard County
35. Follett
36. Frio County
37. Gainesville
38. Garza County Health Care District
39. Gonzales Healthcare Systems
40. Grapeland
41. Hall County
42. Hamilton County
43. Hamlin
44. Hansford County
45. Hardeman County
46. Harris County
47. Haskell County
48. Hemphill County
49. Higgins-Lipscomb
50. Hood County
51. Hopkins County
52. Houston County
53. Hunt Memorial
54. Hutchinson County
55. Iraan General
56. Jack County
57. Jackson County
58. Jasper
59. JPS Health Network
60. Karnes County
61. Kimble County
62. Knox County
63. Lavaca
64. Liberty County No. 1
65. Lockney General
66. Lubbock County
67. Lynn County
68. Marion County
69. Martin County
70. Matagorda County
71. Maverick County
72. McCamey County
73. McCulloch County
74. Medical Arts Hospital
75. Menard County
76. Midland County
77. Mitchell County
78. Moore County
79. Montgomery County
80. Motley County
81. Moulton Community Medical Clinic District
82. Muenster
83. Muleshoe Area
84. Nacogdoches County
85. Nixon
86. Nocona
87. Nolan County
88. North Runnels
89. North Wheeler County
90. Nueces County
91. Ochiltree
92. Olney-Hamilton
93. Palo Pinto County
94. Parker County
95. Parkland Health & Hospital System
96. Parmer County
97. Rankin County
98. Reagan
99. Refugio County Memorial
100. Reeves County101. Rice
102. Rockdale
103. Sabine County
104. San Augustine City-County
105. Schleicher County
106. Seminole
107. Shackelford County
108. South Limestone County
109. South Randall County
110. South Wheeler County
111. Stamford
112. Starr County
113. Stonewall County
114. Stratford
115. Sutton County
116. Sweeny
117. Swisher Memorial
118. Teague
119. Terry Memorial
120. Texhoma Memorial
121. Thomason General Hospital
122. Titius County Memorial
123. Travis County Healthcare District
124. Trinity Memorial
125. Tyler County
126. University Health System
127. Val Verde County
128. Walker County
129. West Coke County
130. Wilbarger County
131. Willacy County
132. Wilson County Memorial
133. Winnie-Stowell
134. Wood County Central
135. Yoakum

Public hospitals are funded by sales and use taxes.

- Texas law defines a public hospital as "a hospital owned, operated or leased by a county or municipality."[20]
- Texas public hospitals serve residents in all or parts of **27 Texas counties**.[21]

**County indigent health care programs (CIHCPs)** receive a combination of local and state funds to pay health care providers for services delivered to eligible patients. All or portions of **140 Texas counties operate CIHCPs**.

- Counties **must** cover residents with incomes at or below **21 percent** of the federal poverty line, but **may** adopt a less-restrictive income standard.
- CIHCP eligibility criteria also may impose **resource limits** (bank account balances, vehicles, etc.) and **residency requirements**.
- While residency may be a requirement for CIHCP eligibility, **citizenship** is not.

For fiscal 2010, the Legislature appropriated **$7.2 million** to the CIHCP State Assistance Fund.[22]

- **State funding** for CIHCPs is tied to the amount of **local funding** provided. To qualify for state funding, counties must spend more than **8 percent** of their general revenue tax levy on qualified health care expenditures.[23]

**Rural health clinics (RHCs**) and **federally qualified health clinics (FQHCs)** also provide indigent health care. Such clinics provide primary care through physicians, nurse practitioners and physician assistants. Some carry both designations.

- **RHCs** serve Medicare and Medicaid beneficiaries through qualified clinics in **rural and medically underserved** communities.[24]
- **FQHCs** include community health centers, migrant health centers, programs that provide health care for the homeless, public housing primary-care programs and urban Indian and tribal health centers.
  - They receive funding from federal grants, Medicaid, Medicare, private insurance payments and state and local contributions.
  - Nearly **71 percent** of their patients have family incomes at or below the poverty line. About **40 percent** are uninsured and another **35 percent** depend on Medicaid for health care.[25]

*Averaging about 519,000 active and retired enrollees for the year, the group benefits plan cost* **$338** *per member per month.*

## ERS: STATE EMPLOYEE AND RETIREE MEDICAL BENEFITS

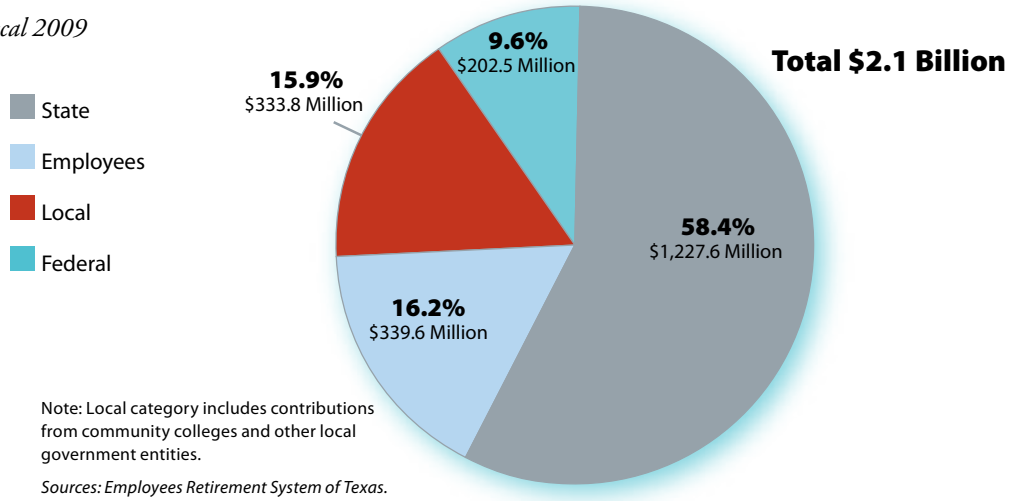
ERS administers HealthSelect, a medical plan that covers about **94 percent** of the employees and retirees of state agencies and higher education institutions as well as their dependents. The remaining ERS members are covered through HMOs administered by Community First Health Plans and the Scott & White Health Plan.[26]

- In fiscal 2009, expenditures for state employee and retiree medical benefits, known as the group benefit plan (GBP), were nearly **$2.1 billion** compared to $1.6 billion in fiscal 2005, an increase of **34 percent**.
- Averaging about 519,000 active and retired enrollees for the year, the group benefits plan cost **$338** per member per month. This is a **29 percent increase** from $261 in fiscal 2005.
- In fiscal 2009, members incurred about **$340 million** in out-of-pocket costs for premiums, deductibles and co-pays (up 15 percent from $295 million in fiscal 2005).
- The state's share of Group Benefit Program expenditures for fiscal 2009 totaled **$1.2 billion**, a 30 percent increase from $946 million in fiscal 2005. Local (primarily community colleges) and federal funding accounted for the remaining **$536 million**, 65 percent more than the $326 million spent in fiscal 2005 **(Exhibit 15)**.[27]

EXHIBIT 15

**EMPLOYEES RETIREMENT SYSTEM OF TEXAS**
**SOURCE OF FUNDS FOR GROUP BENEFITS PROGRAM EXPENDITURES**

*Fiscal 2009*




Note: Local category includes contributions from community colleges and other local government entities.

*Sources: Employees Retirement System of Texas.*

## State Government Pharmaceutical Purchasing

Texas state government purchases prescriptions for numerous state and federal programs, including:

- the Medicaid Vendor Drug Program
- prisons
- state schools
- various health programs

It also subsidizes drug expenditures through **employee and retiree insurance coverage**.

In Texas, the Employees Retirement System (ERS), Teachers Retirement System (TRS), University of Texas System (UT) and Texas A&M University System contract separately with pharmacy benefit management companies (PBMs) for employee drug benefits.

- ERS and TRS contract with CVS Caremark, while UT and Texas A&M contract with Medco Health Solutions.[28]
- In fiscal 2007, ERS, TRS, UT and Texas A&M combined spent more than **$1.3 billion on drug costs for slightly more than 1 million plan members.**[29]

PBMs have helped Texas agencies and institutions adopt a variety of cost strategies, including a **tiered co-payment structure** that provides incentives for the use of less-expensive drugs.

- For example, the plans encourage the use of **generic drugs** by offering them at the lowest co-payment. Brand-name drugs on the preferred drug list (PDL) typically are offered at a midrange co-payment, with the highest reserved for drugs not on the PDL.
- PBMs also **negotiate for manufacturer rebates and lower retail pharmacy prices**, and encourage health plan members to use **mail-in services** to obtain even lower prices.

Texas' **Medicaid Vendor Drug Program** is the state's largest purchaser of prescription drugs, at **$2.1 billion for more than 29.3 million prescriptions in fiscal 2009**.

- In 2004, Texas implemented a **Medicaid preferred drug list** with a prior authorization requirement and began to **negotiate for lower drug prices** from manufacturers.
- The Medicaid PDL saved Texas about **$248.8 million in general revenue in fiscal 2008 and 2009**.[30]
- More than **4,200 Texas pharmacies** contract with the Vendor Drug Program to dispense prescription drugs to Medicaid patients.[31]

In 2002, the Texas Department of Criminal Justice (TDCJ) partnered with the University of Texas Medical Branch at Galveston (UTMB) to take advantage of a federal pharmaceutical program called **"340B"** to obtain significant discounts on prescription **medications for state prisoners**.

- UTMB qualifies for 340B drug pricing because it cares for large numbers of indigent persons as well as adult prisoners, through a contract with TDCJ. TDCJ estimates that 340B pricing saves the state about **$12 million annually**.[32]
- UTMB also obtains 340B pricing for medications prescribed to **Texas Youth Commission inmates** served by psychiatrists in UTMB's service area.[33]

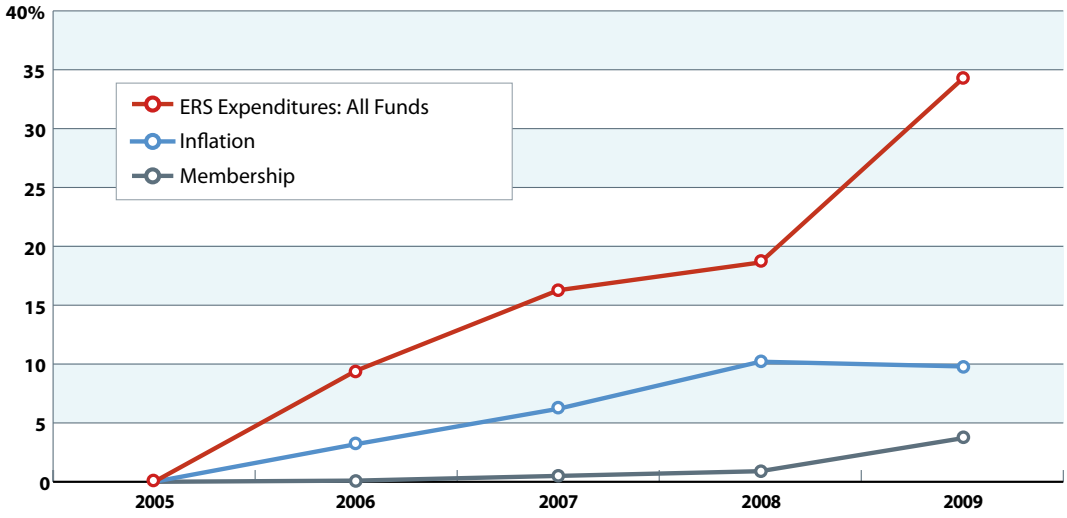
Other Texas state agencies purchase drugs directly from manufacturers or negotiate contracts with wholesalers to obtain lower prices based on volume.

- The state covers benefits for active and retired members, while dependent costs are shared equally between the state and members.
- ERS' total health care spending rose by **34.2 percent** from fiscal 2005 to 2009, compared with membership growth of 3.7 percent and inflation of 9.8 percent **(Exhibit 16).**

EXHIBIT 16

**EMPLOYEES RETIREMENT SYSTEM HEALTH CARE EXPENDITURES VS. MEMBERSHIP AND INFLATION**

*Fiscal 2005 through 2009*




*Sources: Employees Retirement System of Texas and U.S. Bureau of Labor Statistics; calculations performed by Texas Comptroller of Public Accounts.*

## TDCJ: STATE PRISONER HEALTH CARE

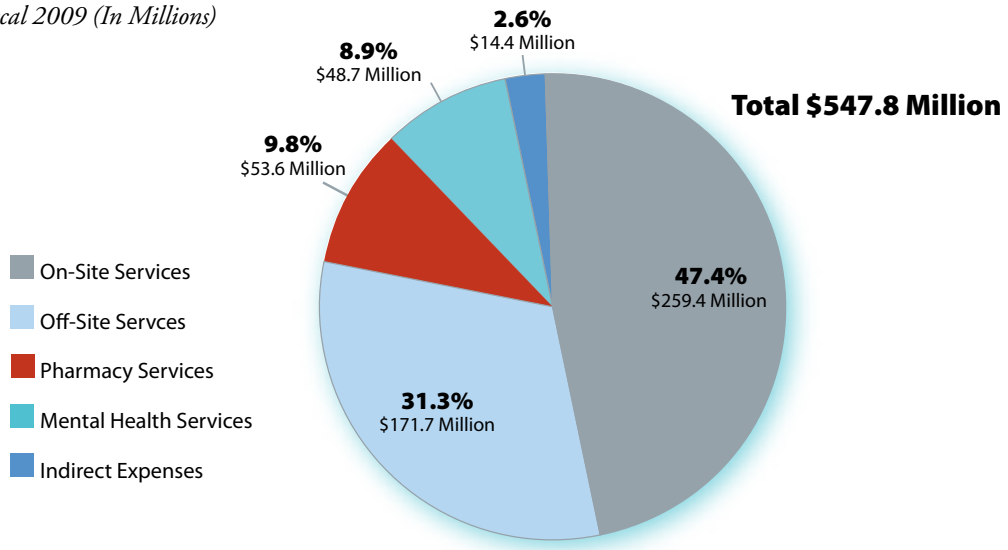
In fiscal 2009, TDCJ provided health care for **150,568 inmates**, making it one of the nation's largest correctional health care systems. TDCJ's health care expenditures totaled **$548 million**, 98 percent of which were funded by state general revenue.

- Most of TDCJ's health care expenditures are for medical care, psychiatric services and substance abuse counseling for incarcerated individuals.
- TDCJ also administers the Medically Recommended Intensive Supervision (MRIS) Program, which moves certain low-risk offenders with medical conditions from incarceration into more cost-effective alternatives.
- TDCJ contracts with the University of Texas Medical Branch (UTMB) and the Texas Tech University Health Science Center (TTUHSC) for health care services **(Exhibit 17)**. The Texas Correctional Managed Health Care Committee manages this partnership.
- UTMB provides about 80 percent of all health care services for the Texas prison population at both in-prison clinics and off-site regional medical facilities.
- Due to mounting expenses, in December 2010 UTMB proposed ending its contract to provide care at the on-site clinics. If that happens, the committee will have to look to other entities to provide health care services for the bulk of TDCJ's prisoners.[34]

EXHIBIT 17

## TEXAS DEPARTMENT OF CRIMINAL JUSTICE TOTAL HEALTH CARE EXPENDITURES BY UNIVERSITY OF TEXAS MEDICAL BRANCH AND TEXAS TECH UNIVERSITY HEALTH SCIENCE CENTER

*Fiscal 2009 (In Millions)*



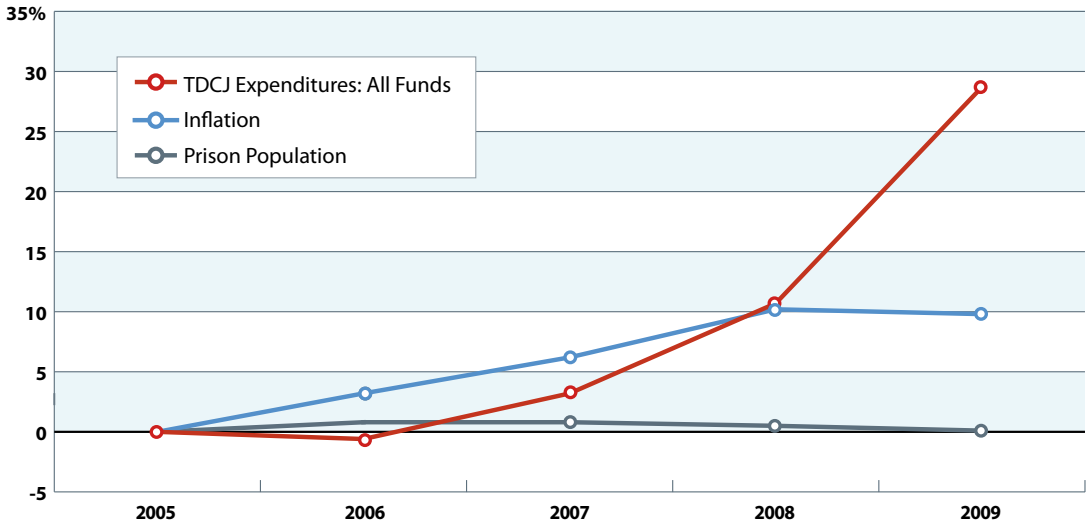

*Sources: Correctional Managed Health Care Committee.*

- TDCJ's health care spending rose by **28.7 percent** from fiscal 2005 to 2009, compared with essentially flat prison population growth and inflation of 9.8 percent **(Exhibit 18)**.

EXHIBIT 18

## HEALTH CARE EXPENDITURES AT THE TEXAS DEPARTMENT OF CRIMINAL JUSTICE VS. PRISON POPULATION AND INFLATION

*Fiscal 2005 through 2009*




*Sources: Texas Department of Criminal Justice, U.S. Census Bureau and U.S. Bureau of Labor Statistics; calculations performed by Texas Comptroller of Public Accounts.*

## COST DRIVERS

Many factors affect health care costs in Texas and the rest of the nation.

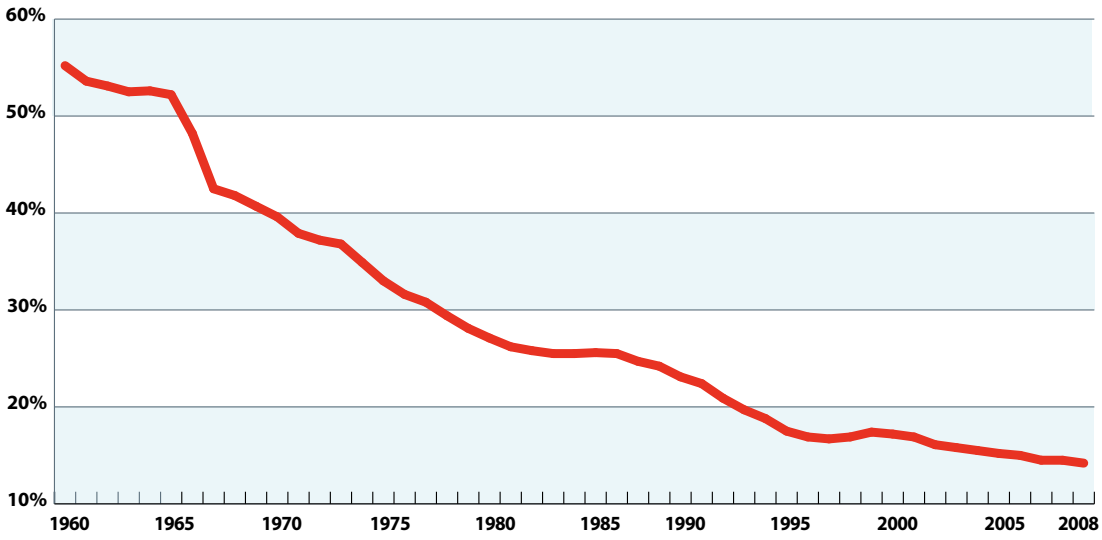
While all of these factors have caused health care costs to rise, each affects various state services and various parts of the state differently. To better understand and identify regional variations in costs, the Comptroller's review team conducted regional comparisons of various state health care services (Medicaid, the Employee Retirement System of Texas and BlueCross BlueShield of Texas). For detailed information on these regional variations, please see Appendix III (http://www.window.state.tx.us/specialrpt/healthcare/).

- Although **technological advances** have led to many lifesaving products, services and drugs, they also drive up the cost of health care significantly. As newer and more effective products, services and drugs have entered the marketplace, their usage has increased. These new treatments often are more costly than older treatments.
- Over the years, **health insurance** has shouldered a greater share of health care costs, lessening the burden on the insured whose co-payments typically account for only a fraction of the total cost of the services patients receive **(Exhibit 19)**. This "insulation" provides little incentive for health care consumers to demand transparent and competitive pricing.

EXHIBIT 19

**U.S. OUT-OF-POCKET COSTS AS A SHARE OF PERSONAL HEALTH CARE SPENDING**

*1960 through 2008*




*Sources: Centers for Medicare and Medicaid Services and Texas Comptroller of Public Accounts.*

## Drug Costs

A number of factors drive increased spending on prescription drugs, but the main ones are:

- **increased usage**
- **rising drug prices**
- changes in the **types of drugs** being dispensed

Between 1997 and 2007, the number of prescriptions drugs purchased in the U.S. rose by **71 percent** (from 2.1 to 3.6 billion annually), compared to an 11 percent population growth.

Rising numbers of **chronically ill Americans** and a growing **elderly population** contributed to this growth.

- In 2007, **51 percent** of all insured Americans were taking at least one medication to treat and control chronic diseases such as diabetes.[35]

Another factor driving the growth in drug sales is the 1997 introduction of television and radio **direct-to-consumer (DTC) advertising** of prescription drugs.

- Drug advertising to the general public totaled **$800 million in 1996** and rose to **$5.6 billion in 2006**. The total declined to less than **$4.6 billion in 2008**, a decrease attributable to the increased popularity of generic drugs; even so, DTC advertising remains an important cost driver.[36]
- Some research indicates that drug makers can gain a 1 percent increase in sales of a drug for each 10 percent increase in DTC advertising.[37]

During the 1997-2007 period, retail prescription **drug prices** rose by an average **6.9 percent annually** (from **$35.72 in 1997** to **$69.91 in 2007**) — more than **2.5 times as fast as inflation**.[38]

- Such increases reflect the shift from older, lower-cost drugs to higher-cost, brand-name drugs, as well as new specialty drugs for cancer and other complex health conditions.

**Development costs** required to introduce new drugs, such as clinical trials, can be extremely costly. Pharmaceutical companies compensate for these costs by raising prices.[39]

Private companies and governments alike have looked for ways to **control drug costs**.

- **Pharmacy benefit managers (PBMs)**, companies that administer drug benefits for health plans, health maintenance organizations and employers, provide:
  - **drug utilization reviews** to evaluate the appropriateness and cost-effectiveness of drug therapies;
  - **case management**, to more efficiently manage high-cost chronic diseases; and
  - **negotiations** for favorable prices from both drug manufacturers and retail pharmacies.

*The provider shortage is most acute in the* **rural areas** *in the West, South and Panhandle areas of the state*

- Texans increasingly rely on **specialists** for medical treatment. Between 2000 and 2010, the number of specialty physicians in Texas rose by 37 percent, while the number of primary care physicians rose by just 20 percent. In the same period, the Texas population grew by 20.6 percent.
- About one in seven Texans lives in counties with **shortages of health care professionals**. The provider shortage is most acute in the rural areas in the West, South and Panhandle areas of the state, where patients have to drive farther and wait longer to see a primary care provider. Many end up seeking more costly care from specialists or emergency rooms.
- **Lifestyle choices** — such as smoking, overeating, inactivity and alcohol consumption — also drive up health care costs due to resulting chronic conditions. Nationwide, 70 percent of all deaths and 75 percent of all health care spending have been attributed to chronic and often preventable diseases.
- **Lack of access to prenatal care** also drives health care costs upward, as women who do not receive adequate prenatal care are more likely to experience complications during and after childbirth.[40] For example, babies whose mothers did not receive prenatal care during pregnancy are three times more likely to have low birth weight.[41]

## Provider Shortages

A **growing shortage of health professionals** threatens to undermine Texans' access to health care. Factors contributing to this shortage include

+ population growth
+ the aging of the existing health care work force
+ insufficient educational and training capacity
+ difficulties in recruiting and retaining health professionals, particularly in rural areas

Supply gaps are most acute in West Texas, South Texas and the Panhandle.[42]

**Primary-care physicians (PCPs)** generally are the first point of contact for patients seeking care, treating a broad range of common problems and coordinating preventive care. Access to primary care is **important to overall health outcomes**.[43]

+ About **3.6 million Texans — one in seven** — live in federally designated **primary-care health professional shortage areas** (HPSAs).[44] The designation identifies areas, populations and facilities as underserved based on population-to-provider ratios.
+ To qualify as a HPSA, a county must have a population-to-PCP ratio of at least **3,500:1**.[45] In 2009, **129 of Texas' 254 counties** qualified for this designation.[46]

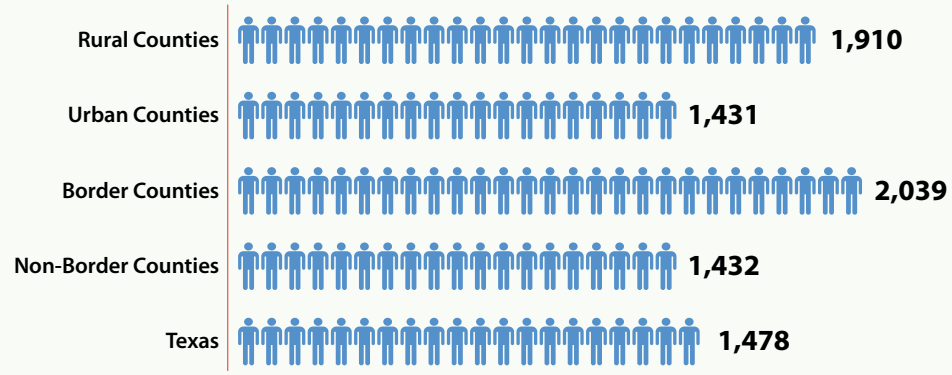
**Rural and border counties** generally have significantly higher population-to-doctor ratios than urban and non-border counties.

+ In 2009, Texas' urban counties had **1,431 residents to every PCP**, compared to **1,910 to one** in the state's rural counties.
+ Border counties, urban and rural alike, had **2,039 residents per PCP**.
+ Twenty-two of Texas' rural counties and three of its urban counties had **no primary-care physicians at all** in 2009.

## TEXAS POPULATION PER PRIMARY CARE PHYSICIAN

*2009*

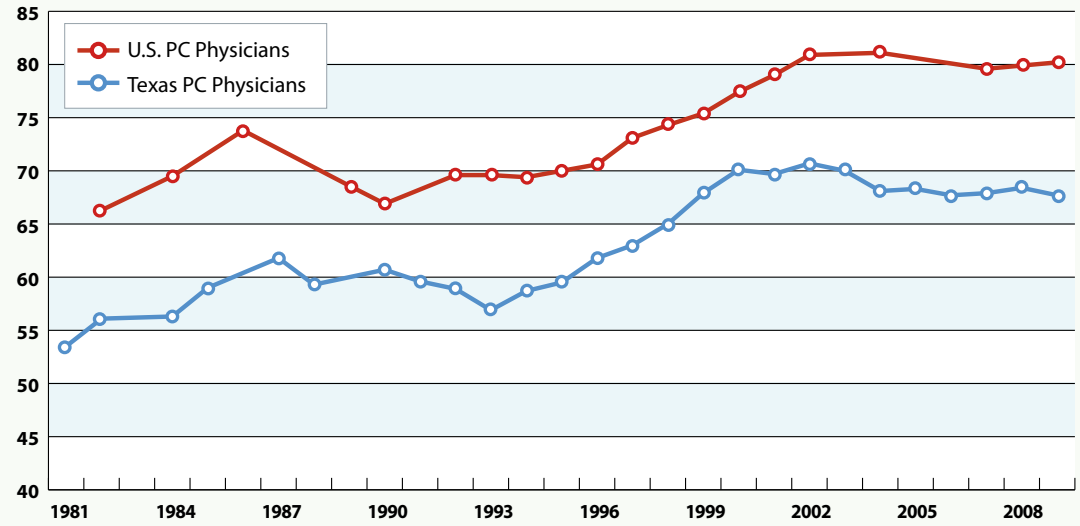
### Texas Population per Primary Care Physician




*Source: Texas Department of State Health Services*

## PRIMARY-CARE PHYSICIANS PER 100,000 RESIDENTS

*Texas vs. the U.S., 1981-2009*




*Source: Texas Department of State Health Services.*

continued

Texas' number of PCPs per 100,000 residents has consistently lagged behind the U.S. average.

According to the Texas Department of State Health Services (DSHS), reasons for regional shortages of PCPs include:

- doctors' concerns about the influence of managed care on their careers
- payment issues
- malpractice rates and lawsuits
- the high cost of medical education
- long work hours
- declining interest in family medicine
- limits on Medicare funding for graduate medical education

The millions to be **newly insured under federal health care legislation** will intensify PCP shortages.

- Even before the legislation, the National Center for Policy Analysis estimated that **45,000 additional doctors** would be needed in the U.S. over the next decade.[47]

Texas medical schools have seen minimal increases in class size in the past 20 years. With limited expansion expected on the horizon, Texas faces a growing shortage.

- Texas already i**mports more than half of its medical school graduates**.[48]

**Nurses** are in short supply as well. According to DSHS, Texas is facing a severe shortage of nurses that may reach **77,428 FTE positions in 2020**.

- As with doctors, Texas lacks sufficient nurse training capacity. DSHS estimates that **54 percent** of qualified applicants were denied admission to RN programs in 2005, due at least in part to a lack of facility space and faculty.[49]

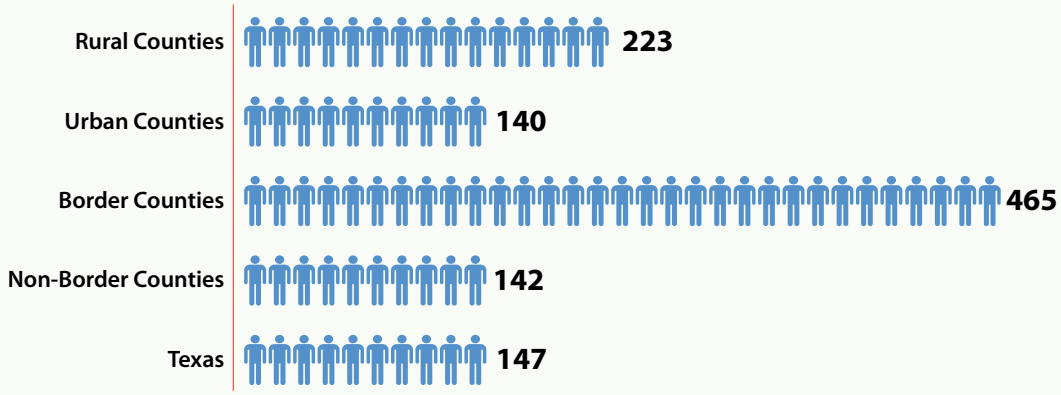
Texas had **169,446** registered nurses in 2009, or **147 Texans for each RN**. Texas' rural counties had **223 people per RN**, while urban counties had **140**. Border counties had a ratio of **465 to one**.

A lack of adequate staffing may force hospitals to **increase their nursing staff's workloads**, which could affect both patient care and outcomes. A shortage also could drive salaries upward, translating into **higher rates** for services as hospitals cope with their own costs.[50]

Nearly **three-quarters of Texas counties (74 percent)** are shortage areas for **mental health professionals**.[51] In 2009, **29 percent** of Texans lived in these counties.[52]

**TEXAS POPULATION PER REGISTERED NURSE**

*2009*




*Source: Texas Department of State Health Services.*

### WHAT'S DRIVING MEDICAID COSTS?

The **increase in enrollment** is the primary cause of increasing Medicaid costs. The number of Texans enrolled in Medicaid rose **78 percent** from fiscal 1999 to 2009.[53] In recent years, the recession and slow economic recovery accelerated the growth in Medicaid enrollment as more families experienced job losses and declines in income and became eligible for Medicaid.[54]

- Although they only represent 31 percent of Texas' clients, the care delivered to the **aged, blind and disabled population** is the costliest, accounting for **58 percent** of the program's expenditures in fiscal 2009. The primary cost drivers within this group include:
  - care for premature infants,
  - kidney disease and renal failure,
  - respiratory disease and chronic obstructive pulmonary disease,
  - chronic mental illness and
  - heart disease and hypertension.
- **Fee-for-service arrangements** cost more than Medicaid's managed care programs (HMOs). HHSC has estimated that expanding the areas covered by STAR and STAR+PLUS managed care plans would result in state savings of nearly **$348 million** in general revenue for the 2012-13 biennium.
- Texas Medicaid also provides **dental services** to children under age 21 on a fee-for-service basis, which costs about **$1 billion** annually. By converting the service delivery model for dental services to a managed care model through a dental management organization (DMO), HHSC could realize significant savings.
- **Potentially preventable readmissions** (PPRs) — readmissions to hospital care due to incomplete or inadequate care after initial admission — also contribute to Medicaid costs, accounting for **$104 million** in state payments to hospitals in fiscal 2009. PPRs represent **3.6 percent** of all Medicaid hospital admissions. A strong physician network working to reduce potentially preventable hospitalizations, along with reductions in payments for PPRs could result in improved care as well as savings to the state. A 2011 HHSC study found that hospitals with the highest PPR rate have two to four more PPRs than hospitals with the lowest rates.[55]

*Readmissions to hospital care due to incomplete or inadequate care after initial admission — also contribute to Medicaid costs, accounting for* **$104 million** *in state payments to hospitals in fiscal 2009.*

## Uncompensated Care

Researchers and policy experts studying health care costs have given significant attention to the effect of **uncompensated care** — health care services, often for the uninsured, provided **without reimbursement** from private insurance, government programs or patient payments.

Uncompensated care is especially **common in Texas**.

- In 2008, about **6.1 million** or **25.1 percent** of adult Texans had no health insurance, compared to **15.4 percent** at the national level.[56]
- The state's uncompensated acute-care hospital expenses (emergency room and other urgent care) totaled **$460 per resident** in 2006, not including uncompensated costs incurred by charitable clinics or physicians. The U.S. average for such costs was **$287**.[57]

The uncompensated care problem is exacerbated by the fact that **uninsured individuals often delay seeking medical care**, allowing their health problems to become more serious. By the time such individuals do seek treatment, their conditions may be much more costly to treat, driving uncompensated costs even higher.[58]

Uninsured Texans are **disproportionately poor**.

- In 2008, the average family income for uninsured persons in the U.S. was **$45,140**, versus **$75,148** for covered families.
- In Texas, **69.5 percent** of the uninsured reported family incomes of less than $50,000, compared to just **50.2 percent** of all Texans.[59]

Uninsured Texans are **more likely to live in poverty**.

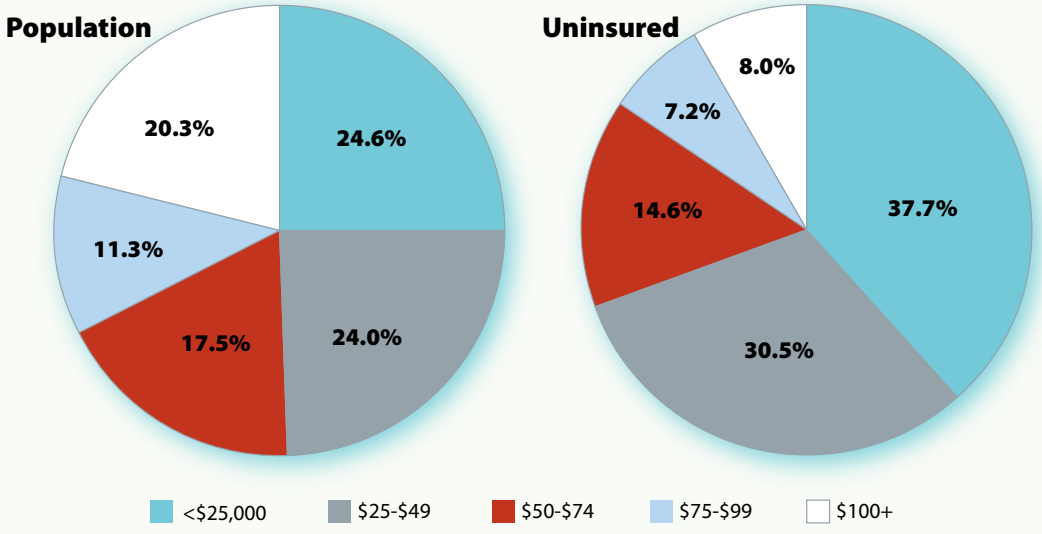
- In 2008, **26.5 percent** of uninsured Texans lived in poverty, versus **15.9 percent** of all Texans; **58.5 percent** of uninsured Texans lived on incomes of less than 200 percent of the federal poverty level, versus **38.8 percent** of all Texans.[60]

The uninsured population also includes a **disproportionately large share of working-age adults**, a group with **limited access to Medicaid benefits**.

- In 2008, adults between age 18 and 64 accounted for **78.7 percent** of Texas' uninsured population compared to **61.6 percent** of the general population.[61]

**FAMILY INCOME BY UNINSURED AND STATE POPULATION**

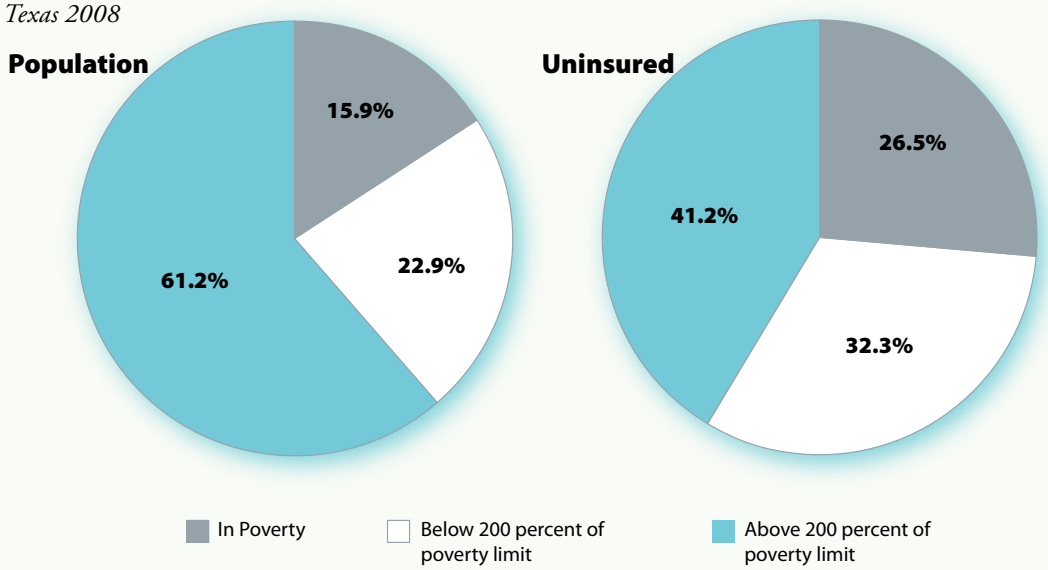
*Texas 2008*




*Source: U.S. Census Bureau*

### POVERTY AMONG THE UNINSURED VS. THE TOTAL STATE POPULATION

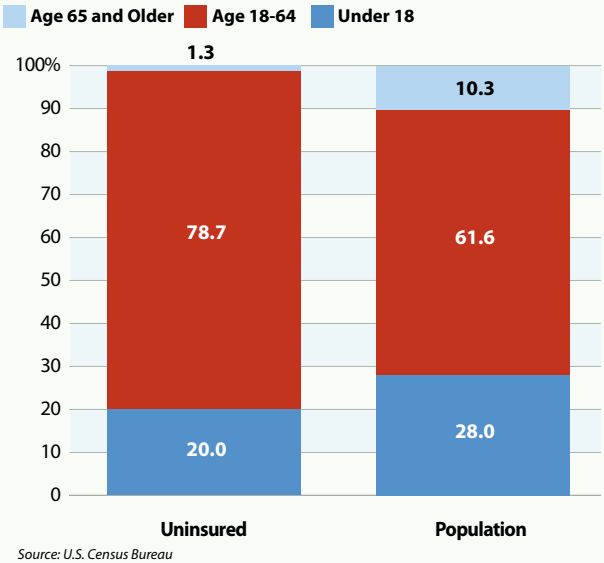
*Texas 2008*




*Source: U.S. Census Bureau*

### AGE BY UNINSURED AND STATE POPULATION

*Texas 2008*




*Source: U.S. Census Bureau*

Much research has been devoted to how health care providers handle uncompensated costs, including a phenomenon called **cost shifting**.

+ Cost shifting occurs when providers attempt to **offset their losses** from uncompensated care by charging those who can pay **higher prices**. The cost thus is "shifted" away from payers who receive free medical care to others who then pay above-cost rates.
+ More specifically, costs are shifted **away from public payers** and the uninsured, and **toward private insurers**.[62]

The extent to which costs truly are shifted among these groups is a topic of considerable debate.

+ Many hospitals are nonprofit entities and may charge lower prices than a for-profit entity would. When facing uncompensated costs, these hospitals may have some "room" to raise the rates they charge to private insurers.[63]
+ Hospitals' ability to shift costs depends on their **ability to negotiate with insurance companies**. This leverage varies over time, depending on the number and size of hospitals and insurance companies in the market as well as other factors.
+ The Congressional Budget Office concluded that in 2008, **hospitals shifted less than half** of an estimated **$35 billion** in uncompensated care costs.[64]

*In fiscal 2009, emergency room expenditures increased by* **22 percent** *from 2008, accounting for just over one-third of the total increase in outpatient costs.*

## WHAT'S DRIVING MENTAL HEALTH CARE COSTS?

Both community- and institutional-based mental health services rely heavily on expensive clinical staff and medications to treat their clients. Texas' mental hospitals provide expensive, round-the-clock psychiatric and medical care and consistently function at nearly full capacity.

- State hospitals must **compete with the private sector for clinical staff**, which comprise about 64 percent of state hospital employees. Because state salaries are significantly lower than market rates, DSHS finds it difficult to recruit and retain psychiatrists. Shortages of psychiatric staff can lead to increased rates of injuries and adverse events, driving costs upward.[65]
- Increases in the **cost of new pharmaceuticals and other new technologies** also have driven up mental health care costs. Newer treatments often are more costly than older ones; better screening and newer, more expensive drugs have driven DSHS' costs for epilepsy treatment significantly upward, for example.
- **Long-term hospitalization** is expensive as well. According to DSHS, 614 individuals had been patients of state mental health hospitals for longer than one year as of September 2010. Data for these patients indicate that some do not require hospitalization but are not capable of living with full independence. Some states use a "**step-down**" alternative program whereby patients receive the care they need through state contracts with residential facilities at a lesser cost than fully hospitalized patients. Texas does not yet have step-down alternatives, but DSHS is examining them as a potential source of savings.[66]

### WHAT'S DRIVING STATE EMPLOYEE AND RETIREE MEDICAL BENEFIT COSTS?

Price inflation and the number and complexity of services provided to ERS members and their dependents are driving costs in the group benefit program. Hospitalization costs have risen due to reduced competition, nursing shortages and high-tech radiology, such as magnetic resonance imaging (MRIs) and computerized axial tomography (CAT scans). Specifically, cost drivers include:

- **medical inflation**. For example, while outpatient visits were down 8.4 percent from 2008 to 2009, the amount paid for outpatient visits rose by **21.5 percent**.
- **emergency room usage**. In fiscal 2009, emergency room expenditures increased by **22 percent** from 2008, accounting for just over one-third of the total increase in outpatient costs. This translates to more than **$1 million a month** in increased medical spending.
- the increased use of **high-tech radiology**. From 2008 to 2009, high-tech radiology expenditures increased by **11.7 percent** per participant, as more providers moved away from using X-rays as a diagnostic tool, and toward MRI and/or CAT scans.
- the cost of **specialty drugs** (drugs that require special handling or monitoring and are used to treat complex medical conditions). Costs for specialty drugs increased by **694 percent** from fiscal 2000 to fiscal 2009. And while specialty drugs represent less than 0.5 percent of all prescriptions, they make up **13.4 percent** of annual prescription drug costs.
- the **aging of ERS members**, which drives up the number of doctor visits and drug prescriptions, particularly of costly specialty drugs. HealthSelect members and their spouses were an average of five years older in fiscal 2009 than in fiscal 1999.

It should be noted that while co-payments and other direct patient costs have fallen as a share of health care spending on the national level, this is not the case at ERS. From fiscal 2005 to fiscal 2009, these costs increased **15.3 percent** for ERS members.[67]

*Costs for specialty drugs increased by* ***694 percent*** *from fiscal 2000 to fiscal 2009.*

*TDCJ estimates that approximately 19,700 TDCJ offenders have the* **Hepatitis C** *virus.*

## WHAT'S DRIVING STATE PRISONER HEALTH CARE COSTS?

The number of offenders with mental illness and chronic conditions and infectious diseases continues to grow, and treatment standards for these conditions have become more sophisticated and expensive.

- In fiscal 2009, **9,200** TDCJ offenders were diagnosed with a **serious mental illness**. From 2002 to 2009, the share of the prison population with mental illness rose from 10.4 percent to **12.9 percent**. Serious mental illnesses include major depressive disorder, bipolar disorder, schizophrenia or other psychotic disorders. In fiscal 2009, TDCJ spent **$1.1 million** on psychotropic drugs.
- According to the Correctional Managed Health Care Committee, TDCJ offenders are more likely than the general population to engage in **risky behaviors**, such as drug and alcohol abuse, smoking and engaging in unprotected sex. These behaviors lead to an increased rate of chronic and infectious disease.
- **Texas prisoners are aging**, which increases the incidence of chronic conditions such as cardiovascular diseases, kidney failure and diabetes.
  - Offenders over the age of 50 years have increased at a faster rate than the overall TDCJ population. From fiscal 2004 to 2009, the population of aging offenders increased by **38 percent**.
  - Older offenders make up 15.5 percent of the TDCJ population but account for **51 percent** of hospital and specialty service costs.
- The most prevalent **cardiovascular diseases** in the Texas prison population are hypertension and coronary artery disease (CAD). UTMB provides care for 27,500 offenders with hypertension and 5,000 with CAD. In the past decade, prescriptions to address these conditions have increased by **682 percent**. In fiscal 2009, the state spent more than **$1.4 million** on these drugs.
- In fiscal 2009, more than 800 TDCJ offenders had some degree of **kidney failure**. An average 191 of those offenders required dialysis at a total cost of **$4.1 million** or $21,500 per patient. The dialysis medications cost an additional **$1.4 million**.
- About 8,000 TDCJ offenders received treatment for **type 1 or type 2 diabetes** through UTMB in fiscal 2009. TDCJ purchased nearly 200,000 prescriptions for insulin and hypoglycemic medications at a cost of **$361,000**.
- In fiscal 2009, TDCJ filled nearly 114,000 prescriptions for **asthma medication** at a total cost of **$2.7 million**.
- **Infectious diseases such as HIV and Hepatitis C require costly medications and procedures**.
  - In fiscal 2009, about 1.6 percent of the TDCJ population was **HIV positive**. Antiretroviral drugs for HIV positive offenders cost the state **$17.8 million** in fiscal 2009, representing **46 percent** of all of TDCJ's pharmaceutical purchases.
  - TDCJ estimates that approximately 19,700 TDCJ offenders have the **Hepatitis C** virus (HCV), the leading cause of end-stage liver disease, which requires frequent hospitalizations and emergency room services. In fiscal 2009, an average of 251 HCV-positive offenders received antiviral treatment each month at a total cost of **$1.5 million**, or 4 percent of all pharmaceutical expenditures.[68]

## Electronic Medical and Health Records

Medical and technological professionals are working to improve the efficiency of health care through the development of **digital medical and health records**.

**Health information exchanges (HIEs)** now being developed will digitize personal medical records so that they can be shared electronically among medical professionals. HIE data could be used to:

- communicate information about general health trends among populations
- spot and report disease outbreaks
- guide medical research
- improve patient care by allowing physicians and other medical professionals to coordinate diagnoses, medications and treatments.

HIEs would collect two types of data.

- An **electronic medical record (EMR)** would represent information on a patient's interaction with a single health care provider, including office visits, illnesses, diagnoses, test results, prescriptions and vital statistics.
- An **electronic health record (EHR)** assembles EMR information from **all** of a patient's health care providers, past and present.[69]

EHRs are intended to:

- provide better, faster and more widely distributed medical information;
- reduce overtesting, overbilling, overmedicating, overpricing and human error; and
- improve physician and medical staff productivity.

Developing the **infrastructure** to store and transmit EMR/EHR data is a significant challenge.

- In 2009, only **6 percent** of the nation's physicians and **2 percent** of its hospitals had the technology needed to collect and use EHRs and EMRs.[70]

### COSTS

One major roadblock to EHR is cost, which can begin at **$30,000 or more** per physician.

- According to the National Center for Health Statistics, almost **44 percent** of physicians say they use some kind of automated health record system, but that the cost has prevented them from buying a more robust one. [71]

continued

### FEDERAL FUNDING

The American Recovery and Reinvestment Act (ARRA) and Health Information Technology for Economic and Clinical Health Act (HITECH) dedicated **$29 billion in federal stimulus funding** through 2016 to the development and widespread implementation of EHRs.[72]

- HITECH set aside **$564 million** of stimulus funds to develop HIEs in the states. States must provide matching funds for the effort beginning in 2011.[73]
- **Texas** will receive **$28.8 million** in ARRA funding over a total of four years for HIE development. The Texas Health and Human Services Commission (HHSC) and the new Texas Health Services Authority (THSA) are leading the project.[74]
- The 2007 Texas Legislature created THSA as a nonprofit corporation to **coordinate and promote the development of electronic HIEs in Texas**.[75]
- In April 2010, HHS awarded $35.7 million in ARRA funds to four Texas **Regional Extension Centers (RECs)**. These are intended to help physicians and other healthcare providers create a statewide EHR system.
  - The North Texas Regional HIT Extension Center Consortium received $8.5 million;
  - the West Texas Health Information Technology REC, $6.7 million;
  - the CentrEast REC, $5.3 million;
  - and the Gulf Coast HITECH Extension Center, $15.3 million.[76]

In July 2010, the U.S. Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health Information Technology (ONC) issued their **final rules** for EHR development under ARRA.

- The rules define EHR technology and other program requirements Medicaid and Medicare providers must follow to qualify for ARRA incentive payments. These payments end in 2014.[77]

### TEXAS PILOT PROJECT

The 2009 Legislature established the **Electronic Health Information Exchange Pilot Project** to develop an EHR system for participants in the Children's Health Insurance Program and Medicaid, in at least one Texas urban area.[78]

- HHSC has begun developing this project. Eventually, all EHR networks will link and be compatible with the **Nationwide Health Information Network (NHIN)**, a "network of networks."[79]

## Getting the Most from Each Dollar

Early drafts of the Texas budget for 2012-2013 include significant cuts in many areas of spending, including health care. Due to budget constraints, the 2011 Legislature must closely examine every area in which tax dollars are spent to ensure that these funds are put to the best possible use. Areas of health care-related spending that legislators are examining include:

### INTERSTATE HEALTH CARE COMPACT

- Participation in an interstate Health Care Compact could give Texas greater authority in health care funding decisions, potentially leading to savings.
- The proposed Health Care Compact, an agreement among several states in response to federal health care legislation, is an idea gaining ground throughout the country through the efforts of the nonprofit Health Care Compact Alliance.
- Under this agreement:
  - states would have full discretion over health care spending;
  - state regulations would supersede federal regulations, including the Affordable Care Act;
  - states would receive federal funding each year in the form of direct block grants based on 2010 federal funding levels, with annual adjustments for inflation and population changes;
  - an advisory committee would be created to share data and best practices throughout the country; and
  - at any time, member states could withdraw from the compact.[80]
- H.B. 5 by Rep. Lois Kolkhorst and S.B. 25 by Sen. Jane Nelson would make Texas part of the Health Care Compact; if passed, the compact would have to be approved by the U.S. Congress to take effect. [81]
- A separate piece of state legislation, H.B. 1008 by Rep. Tryon Lewis, would establish a compact among states to replace Medicaid with a new federal program offering direct grants to states. [82]

### LEGISLATION TO DEFUND ABORTIONS AND ENTITIES THAT PERFORM THEM

- H.B. 816 and S.B. 404, by Rep. Todd Hunter and Sen. Glenn Hegar, respectively, would prohibit insurance plans in any state health benefit exchange established in accordance with federal health care legislation from providing abortions, except in cases in which an abortion is needed to help save the woman's life.[83]
- The Women's Health Program, created in 2005 by Texas S.B. 747, provides Medicaid funding for free family planning services for qualifying women. The funds are sent to clinics and affiliates throughout Texas with the stipulation that the Health and Human Services Commission may not contract with entities or affiliates of entities that perform abortions.[84]
- In response to a July 2010 request by Sen. Bob Deuell, the Texas Attorney General's Office upheld this legislation in February 2011.[85]

### SONOGRAM LEGISLATION

- Current legislation sponsored by Senator Dan Patrick and Representative Sid Miller would require a doctor to perform a sonogram and document an audible fetal heartbeat on women seeking abortions between 72 and 24 hours before the procedure is performed.

The Texas Department of State Health Services would inspect physician offices to ensure compliance with this law and absorb all costs. The Legislative Budget Board estimates no costs to the state from either of these bills.[86]

# Proposals

Through a careful review of the cost driver data — along with conversations with state agencies, stakeholders and other health care experts — the Comptroller has analyzed the following list of proposals, several of which are currently under consideration by the Texas Legislature.

These proposals target the biggest cost drivers in the largest categories of health care spending in state government. By focusing on these programs, state lawmakers can more effectively control costs without adversely affecting the delivery of vital health care services.

## MEDICAID

**PROPOSAL:**

### 1. Expand Medicaid STAR and STAR+PLUS managed care plans.

HHSC should expand capitated managed care services (prospective payment or premium) to urban areas in south Texas and counties bordering its current managed care service delivery areas in Lubbock, San Antonio, Austin, Houston, Corpus Christi and El Paso. State law currently prohibits Medicaid managed care in three south Texas counties (Cameron, Hidalgo and Maverick).

HHSC estimates that expanding State of Texas Access Reform (STAR) coverage into contiguous counties would begin by September 2011, while STAR+PLUS would begin by March 2012. In south Texas, managed care expansion (STAR and STAR+PLUS) would begin by March 2012.

The expansion would decrease client service costs and increase state revenues from taxes on insurance premiums. A reduction in state spending would result in a reduction of federal funds. HHSC estimates all-funds savings and revenues of **$240.4 million** in fiscal 2012 and **$492.2 million** in fiscal 2013.

**PROS:**

- Expansion of STAR+PLUS managed care to South Texas and other parts of the state would help reduce state costs for the Medicaid program by ensuring efficient delivery of patient services.
- STAR+PLUS has proven successful at containing costs in several major areas of the state by helping to ensure that patient needs are met with necessary services only.
- By providing coordinated care through networks of contracted providers, HMOs can engage in practices such as medical necessity audits and preauthorization to reduce the incidence of costly and unnecessary procedures.

- South Texas and counties contiguous to current STAR+PLUS counties would be appropriate for managed care since those areas already have the health care infrastructure — hospitals, physician networks and clinical support systems — needed for successful extension of the program.

**CONS:**

- Medicaid reimbursement rates are already well below the market rate and any further reductions in payments imposed by HMOs could harm health care providers financially.
- With respect to services provided at hospitals, shifting more people to managed care could affect the number of services eligible for Upper Payment Limit (UPL) funds, payments designed to make up for low Medicaid reimbursement rates in hospitals providing services under the fee-for-service model. If federal regulations for UPL are not changed to include services paid through a capitated model, a move to managed care could reduce revenues for some hospitals.
- Expansion of managed care to new areas would require careful planning and execution on the part of HHSC and other stakeholders.

**LEGISLATIVE ACTION:**

This proposal is included in both House Bill 1 and Senate Bill 1 (General Appropriations Act). Statutory changes required to implement this proposal are contained in Senate Bill 23 by Senator Nelson, Senate Bill 1181 by Senator Duncan and House Bill 1645 by Representative Zerwas.

**SAVINGS:**

| | GR/GR Dedicated | All Funds |
|---|---|---|
| FY 2012 | $97,137,515 | $240,452,133 |
| FY 2013 | 227,605,162 | 492,191,613 |

**PROPOSAL:**

**2. Provide Medicaid dental services through a capitated managed care arrangement.**

HHSC could include dental services in managed care plans or through a dental management organization. HHSC estimates that this measure could begin by March 2012.

Including dental services in managed care plans or a DMO would decrease client service costs and increase state revenues from taxes on insurance premiums. A reduction in state spending would result in a reduction of federal funds. HHSC estimates savings and revenues of **$37.4 million** in fiscal 2012 and **$138.6 million** in fiscal 2013.

**PROS:**

- Including Medicaid dental services in managed care or DMO plans would allow the state to realize savings by introducing efficiencies into the provision of dental services.
- This type of arrangement would move the state away from the fee-for-service model in Medicaid dental services, ensuring that only necessary dental procedures are performed.
- Use of managed care could increase the expansion of preventive dental services, further reducing costs and creating better health outcomes for patients.

**CONS:**

- Reducing already low Medicaid dental payments by moving to a managed care model could make it even harder for dentists and hygienists to serve Medicaid recipients effectively.
- Such a change also could impede efforts to attract new providers to the program.
- Moving dental services to managed care would require careful planning and execution on the part of HHSC and other stakeholders.

**LEGISLATIVE ACTION:**

This proposal is included in both House Bill 1 and Senate Bill 1 (General Appropriations Act). Statutory changes required to implement this proposal are contained in Senate Bill 23 by Senator Nelson, Senate Bill 1181 by Senator Duncan and House Bill 1645 by Representative Zerwas.

**SAVINGS:**

| | GR/GR Dedicated | All Funds |
|---|---|---|
| FY 2012 | $16,146,024 | $37,363,357 |
| FY 2013 | 85,488,668 | 138,644,798 |

**PROPOSAL:**

### 3. Convert primary care case management areas to the STAR Managed Care model.

HHSC could convert its PCCM services to the STAR program. HHSC estimates that it could replace the current PCCM model by March 2012.

The expansion of managed care would decrease client service costs and increase state revenues from taxes on insurance premiums. A reduction in state spending would result in a reduction of federal funds. HHSC estimates all-funds savings and revenues of **$14.9 million** in fiscal 2012 and **$77.9 million** in fiscal 2013.

**PROS:**

- Managed care would be a more cost-effective way to provide health care to Medicaid recipients.
- Managed care organizations typically have a wider network of providers and specialists, providing patients with more choice. They also can provide **additional benefits** beyond those provided by traditional Medicaid (e.g. dental benefits for adults; contact lenses instead of glasses).

**CONS:**

- Some research shows that individuals treated under a PCCM entity experience improved health outcomes, as the assignment of a patient to a single provider can encourage preventive care such as immunizations and disease prevention.
- Moving to a managed care model might exclude some providers currently participating in the PCCM program, potentially making it more difficult for patients to find treatment, particularly those living in rural areas.
- Moving from the PCCM model to a managed care model would require careful planning and execution on the part of HHSC and other stakeholders.

**LEGISLATIVE ACTION:**

This proposal is included in both House Bill 1 and Senate Bill 1 (General Appropriations Act). Statutory changes required to implement this proposal are contained in Senate Bill 23 by Senator Nelson, Senate Bill 1181 by Senator Duncan and House Bill 1645 by Representative Zerwas.

**SAVINGS:**

| | GR/GR Dedicated | All Funds |
|---|---|---|
| FY 2012 | $ 5,810,949 | $14,873,802 |
| FY 2013 | 55,417,949 | 77,931,298 |

**PROPOSAL:**

**4. Include Medicaid inpatient hospital services in the STAR+PLUS managed care plan.**

Inpatient hospital services for the aged, blind and disabled provided through Medicaid currently are "carved out" of the program's managed care plan and paid through a traditional fee-for-service arrangement.

HHSC estimates that hospital services could be offered through STAR+PLUS by March 2012.

Including inpatient hospital services for the aged, blind and disabled in a managed care plan, would decrease client service costs and increase state revenues from taxes on insurance premiums. A reduction in state spending would result in a reduction of federal funds. HHSC estimates savings and revenues of **$15.6 million** in fiscal 2012 and **$43.1 million** in fiscal 2013.

**PROS:**

- Eliminating the fee-for-service carve-out among the aged, blind and disabled population would reduce expenditures while generating insurance premium tax revenue.
- This population already is being served in a managed care setting, and it would not be burdensome to include acute care services in the system as well.

**CONS:**

- Shifting more people and services to managed care could make some services ineligible for Medicaid Upper Payment Limit (UPL) funds, payments designed to make up for low Medicaid reimbursement rates in the state's fee-for-service model. If federal regulations for UPL were not changed to include services paid for through a capitated model, a move to managed care could reduce revenues for some hospitals.
- Eliminating the carve-out for inpatient hospital services would require careful planning and execution on the part of HHSC and other stakeholders.

**LEGISLATIVE ACTION:**

This proposal is included in both House Bill 1 and Senate Bill 1 (General Appropriations Act). Statutory changes required to implement this proposal are contained in Senate Bill 23 by Senator Nelson, Senate Bill 1181 by Senator Duncan and House Bill 1645 by Representative Zerwas.

**SAVINGS:**

| | GR/GR Dedicated | All Funds |
|---|---|---|
| FY2012 | $ 6,166,172 | $15,630,346 |
| FY2013 | 22,774,705 | 43,145,813 |

**PROPOSAL:**

**5. Reduce payments for preventable readmissions.**

HHSC could reduce Medicaid hospital payments when patients are readmitted for preventable complications.

HHSC is developing rules and business processes to support the identification and reporting of potentially preventable readmissions. As of January 2011, HHSC planned to apply PPR analytics to Medicaid-paid hospital claims to establish state- and hospital-specific PPR rates by disease condition and for other variables.

**PROS:**

- Reducing payments for preventable readmissions would encourage hospitals to provide a superior level of care by taking actions to avoid patient complications.
- Reducing payments for preventable readmissions would reduce state health care costs through the avoidance of preventable acute conditions.

**CONS:**

- Opponents say that the prevention of hospital readmissions is difficult to achieve in practice. It can be difficult to determine what constitutes a "preventable" complication versus one out of a hospital's control.
- Many readmissions are the result of patient behavior after discharge, a factor over which a hospital has limited control. If such behavioral problems are not addressed, a hospital could see its payment reduced even though a readmission was not actually preventable from the hospital's standpoint.
- Reducing payments for preventable admissions may be difficult given the existing physician shortages in some areas of the state. A strong physician network is needed to successfully reduce preventable readmissions.

**LEGISLATIVE ACTION:**

This proposal is included in both House Bill 1 and Senate Bill 1 (General Appropriations Act). Statutory changes required to implement this proposal are contained in Senate Bill 7 by Senator Nelson.

**SAVINGS:**

Cannot be estimated. Potentially preventable admissions in Texas totaled 14,318 in fiscal 2009, resulting in **$104 million** in state Medicaid costs. Reducing payments for preventable admissions could reduce these costs in future years.

**PROPOSAL:**

### 6. Institute a statewide smoking ban.

The state could ban smoking in workplaces and public places, with penalties for violations. Such a ban would generate savings by reducing the need for health care services spurred by exposure to second-hand smoke, such as those for persons who work in smoke-associated environments. The ban also could generate long-term savings if it reduces the number of Medicaid recipients who smoke.

HHSC estimates savings of **$15.4 million** in fiscal 2012, with the potential for higher savings in later years.

**PROS:**

- Reduces short-term health costs associated with second-hand smoke.
- Could reduce long-term health costs by reducing the number of Medicaid recipients who smoke.
- Employees would no longer be exposed to hazardous second-hand smoke at their workplaces.
- Currently, some localities have smoking bans in place while others do not. The ban would create uniform requirements across the state.

**CONS:**

- State sales tax collections could decline, as a smoking ban could discourage smokers from doing business at certain establishments.
- Reductions in the incidence of smoking also would result in declining state cigarette sales tax collections.
- Businesses could suffer sales declines if smokers no longer visit the establishments because they are not allowed to smoke.
- Opponents argue that a statewide smoking ban infringes on property rights of business owners that would be affected by the ban.

**LEGISLATIVE ACTION:**

House Bill 670 by Representative Crownover and Senate Bill 355 by Senator Ellis address this proposal.

**SAVINGS:**

| | GR/GR Dedicated | All Funds |
|---|---|---|
| FY2012 | $6,388,351 | $15,364,000 |

## MENTAL HEALTH AND HOSPITALS

**PROPOSAL:**

**7. Create "step-down" alternatives for individuals who have spent more than one year in a state mental health hospital but do not require full hospitalization.**

An example of a step-down alternative is a residential facility that provides short-term therapeutic care to individuals at risk of hospitalization due to mental illness. In 2011, DSHS will implement a state hospital step-down program. It will convert existing beds to behavioral health-certified beds for patients who require a lower standard of care and less frequent checkups by psychiatrists and other staff.

**PROS:**

- Step-down alternatives provide for a transition from full hospitalization to independent living.
- Step-down alternatives could reduce the number of full-time patients in state hospitals, leading to savings.
- DSHS anticipates savings through reduced staff hours.

**CONS:**

- Psychiatrists perform fewer checkups on patients in step-down alternatives.
- Some step-down alternatives involve contracting with residential facilities; such contracts would require outlays from DSHS.
- Implementation of step-down alternatives would require careful planning on the part of DSHS and other stakeholders.

**LEGISLATIVE ACTION:**

This proposal is included in both House Bill 1 and Senate Bill 1 (General Appropriations Act). Statutory changes required to implement this proposal are contained in Senate Bill 7 by Senator Nelson.

**SAVINGS:**

DSHS estimates annual savings of **$3 million** from its state hospital step-down alternative program, after any additional outlays from DSHS.

**PROPOSAL:**

**8. Undertake cleanliness initiatives in state hospitals such as those implemented under the Michigan Keystone Intensive Care Unit Project.**

Led by the Michigan Health and Hospital Association, the Michigan Keystone Intensive Care Unit is a partnership between regional hospitals that agree to implement interventions to improve patient safety and reduce health care costs. To reduce the incidence of catheter-related bloodstream infections, participating ICUs followed a cleanliness checklist that included hand washing, cleaning patients' skin, the use of cap, gown and mask and more careful catheter use. Over the course of 18 months, the initiative resulted in a 66 percent reduction in infections, as well as $200 million in savings.

While no such initiative exists in Texas, recent legislation has focused on hospital cleanliness. Senate Bill 203, passed in 2009, expands reporting requirements for preventable adverse events such as health care-associated infections, requiring hospitals to report occurrences and causes of bloodstream infections to DSHS. DSHS is implementing this legislation as part of its ongoing patient safety initiative.

**PROS:**

- If adopted in Texas, such an initiative could significantly reduce the incidence of adverse events and improve patient outcomes.
- Increased cleanliness would produce savings for state mental health hospitals through the reduced incidence of bloodstream infections and other adverse events.

**CONS:**

- Initiatives such as the Michigan Keystone Intensive Care Unit Project require planning, collaboration and compliance from participating hospitals.
- New cleanliness initiatives involve additional staff time, which may be difficult for hospitals already experiencing physician shortages.

**LEGISLATIVE ACTION:**

House Bill 1657 by Representative Davis and Senate Bill 620 by Senator Nelson address this proposal.

**SAVINGS:**

DSHS has not estimated the impact of such a program.

## STATE EMPLOYEE AND RETIREE MEDICAL BENEFITS

**PROPOSAL:**

**9. Require retired state and higher education employees to pay a portion of their health care benefits based on their years of service.**

Seventeen states have some form of tiered contribution system under which retiree benefits are based on length of service to the state. Alabama, for instance, pays 100 percent for those with 25 years of service and decreases the contribution by 2 percent for each year of service less than 25 years.

If Texas adopts a tiered system in which retirees with 10 to 15 years of service pay 50 percent of their own costs and 75 percent of their dependents' costs; those with 15 to 20 years of service pay 25 percent of their own cost and 62.5 percent of dependent costs; and those with 20 or more years of service pay zero percent of their own cost and 50 percent of dependents' costs, ERS estimates the state could save **$56.5 million** annually.

**PROS:**

- Savings for the biennium could be **$113 million**.
- Closes an insurance program funding gap and helps to ensure that all retired state employees and their dependents have access to affordable health insurance.

**CONS:**

- Retirees would have to pay more for health insurance coverage, making state employment less attractive.

**LEGISLATIVE ACTION:**

This proposal is included in both House Bill 1 and Senate Bill 1 (General Appropriations Act) through a rider in the Employee Retirement System's bill pattern.

**SAVINGS:**

| | GR/GR Dedicated | All Funds |
|---|---|---|
| FY 2012 | $34,300,000 | $56,500,000 |
| FY 2013 | 34,300,000 | 56,500,000 |

**PROPOSAL:**

**10. Require tobacco users to pay more for their health insurance benefits than non-tobacco users.**

Many states enforce financial penalties on employees with unhealthy behaviors. Non-smoking state employees in at least nine states pay lower premiums than smokers. ERS estimates a 15 percent surcharge on its total health insurance contributions for smokers would generate $59 million in revenue annually. Revenue from this surcharge could be used to offset future contribution increases.

**PROS:**

- This surcharge could offset the increased medical expenses incurred by tobacco users and generate **$118 million** in savings over the biennium.
- It might serve as an extra incentive to quit using tobacco, since the extra employee expense would apply only to tobacco users.

**CONS:**

- Verifying state employees' smoking status could prove difficult.
- Additional costs might be involved in enforcing this surcharge.

**LEGISLATIVE ACTION:**

House Bill 1166 by Representative Zerwas addresses this proposal.

**SAVINGS:**

| | GR/GR Dedicated | All Funds |
|---|---|---|
| FY 2012 | $28,900,000 | $59,000,000 |
| FY 2013 | 28,900,000 | 59,000,000 |

| | |
|---|---|
| **PROPOSAL:** | **11. Charge state employee dependents (spouses) a higher premium if they turn down coverage offered by their employers to join ERS.**<br><br>ERS has not estimated the impact from this fee.<br><br>**PROS:**<br><br>• This practice may encourage employee dependents to purchase insurance coverage through their own employer, thus saving the state the expense of providing them with coverage.<br><br>**CONS:**<br><br>• Some dependents may not elect to get coverage from the state or their employer because they cannot afford the premiums.<br><br>**LEGISLATIVE ACTION:**<br><br>House Bill 3373 by Representative Murphy addresses this proposal.<br><br>**SAVINGS:**<br><br>ERS has not estimated the impact from this fee, but expects that it would result in a savings to the health insurance plan. |

**PROPOSAL:**

**12. Allow ERS to offer varying plans with different benefit packages that increase member cost sharing (of both out-of-pocket costs and premium contributions).**

Increasing member contributions would require a legislative change to the contribution strategy, and could require a contribution by all employees and retirees (no grandfathering). Contribution levels would vary according to the level of benefits. For example, the state could pay 90 percent of the cost of a high-deductible health plan, while members selecting a more generous plan (such as HealthSelect) would pay more for the difference in coverage.

If ERS allowed covered employees to choose among multiple health plans, it could help create a consumer-driven member system in which employees aid in cost-reduction efforts by selecting plans that meet their needs while reducing the state's contribution. ERS has not estimated the impact of varying plans.

**PROS:**

- This would allow employees to determine the amount of coverage for which they are willing to pay.

**CONS:**

- Some may elect to enroll in a high-deductible health plan due to financial considerations, when a more expensive plan might better address their needs.
- Healthy people may pick the high-deductible plan, while sick or less-healthy people might choose HealthSelect, thereby increasing the plan's cost.

**LEGISLATIVE ACTION:**

House Bill 1766 by Representative Crownover and Senate Bill 1362 by Representative Laubenberg address this proposal.

**SAVINGS:**

ERS has not estimated the impact of offering varying plans, but estimates it would result in savings to the health insurance plan.

**PROPOSAL:**

**13. Allow retirees to opt out of ERS coverage in lieu of a Medicare supplemental policy paid for with state funds.**

Such a plan would allow retirees to receive a contribution allowance from the state to purchase a Medicare supplemental policy from the private insurance market; the state's cost would be lower than the cost of participation in the state health care plan. This recommendation would allow retirees to purchase the type and level coverage they deem necessary for their unique situations. ERS has not estimated the impact of this option.

**PROS:**

- This would allow every retiree to determine the level of coverage for which they are willing to pay.

**CONS:**

- Some may elect to purchase a Medicare supplemental policy due to financial considerations when they should be enrolled in a more comprehensive plan that more adequately addresses their needs.

**LEGISLATIVE ACTION:**

House Bill 3496 by Representative Darby addresses this proposal.

**SAVINGS:**

ERS has not estimated the impact of this option, but expects that it would result in a savings to the health insurance plan.

| STATE PRISONER HEALTH CARE | |
|---|---|
| **PROPOSAL:** | **14. Reduce prison terms for certain elderly, non-violent offenders.**<br>Many states have passed new legislation reducing their penalties for certain types of drug possession and other non-violent crimes. Alabama, Kentucky, Colorado, Iowa, Louisiana, Vermont, Florida, South Carolina, Washington, New York and New Jersey are among states that have altered sentencing, probation or parole policies for some nonviolent offenders.<br>**PROS:**<br>• Aging offenders are responsible for 51 percent of TDCJ's hospital and specialty service costs. Policies resulting in the early release of certain nonviolent offenders would reduce the state's costs of providing health care for this subgroup.<br>• Such policies would allow the state to focus its resources on high-risk and recently incarcerated offenders.<br>**CONS:**<br>• New policies regarding changes in sentencing, probation and parole may generate public safety concerns.<br>**LEGISLATIVE ACTION:**<br>House Bill 3366 by Representative White and House Bill 3763 by Representative Marquez address this proposal.<br>**SAVINGS:**<br>TDCJ has not estimated the impact of this option. |

**PROPOSAL:**

**15. Evaluate the Medically Recommended Intensive Supervision (MRIS) Program for potential savings.**

MRIS releases offenders who pose a minimal safety risk to the public and places them in more cost-effective alternative settings. Under the current screening and review process, the Texas Correctional Office on Offenders with Mental or Medical Impairments (TCOOMMI) first screens offenders who may be eligible. The Board of Pardons and Paroles then reviews their cases and makes release decisions. Currently, the board approves the release of just a fourth of those recommended by TCOOMMI for MRIS.

Further expansion of this process could lead to greater savings as more offenders are placed into alternative settings.

**PROS:**

- Aging offenders are responsible for 51 percent of TDCJ's hospital and specialty service costs. Policies resulting in early release of certain non-violent offenders would reduce the state's health care costs.

**CONS:**

- Policies that result in the release of offenders prior to the completion of their sentences may generate public safety concerns.

**LEGISLATIVE ACTION:**

House Bill 3538 by Representative Thompson and House Bill 3761 by Representative Marquez adress this proposal.

**SAVINGS:**

TDCJ has not estimated the impact of this option.

## HEALTH PROFESSIONALS

**PROPOSAL:**

**16. Texas should consider ways to increase its physician work force.**

With its rising population, Texas needs more doctors, but given the current budget challenges facing legislators, additional funding for state entities that recruit, train and retain health care professionals may not be available. Other options for expanding the physician work force, however, should be considered. The Texas Medical Board, in coordination with the Health Professional Council, should conduct an interim study that explores ways to train and attract more health care professionals in Texas.

**PROS:**

- Increasing the number of physicians in Texas would increase access to health services.
- An expanded physician work force could encourage preventive care more effectively, reducing the incidence of emergency room visits for health problems that could have been prevented by earlier treatment. Such changes in behavior could lead to long-term savings.

**CONS:**

- The proposed study would not result in any immediate action or funding by the state.

**LEGISLATIVE ACTION:**

There is no legislation required or currently filed to address this proposal.

**SAVINGS:**

There should be no significant fiscal impact associated with this study.

**To view the endnotes and appendices for this study, please visit**
**www.window.state.tx.us/specialrpt/healthcare/**

The **Endnotes** show detailed information about the sources used in the report. **Appendix I** contains the definition of health care as used in this report; **Appendix II** is a detailed examination of health care expenditures by agency; and **Appendix III** contains information regarding regional variations in state health services costs, comparing Medicaid, Employees Retirement System of Texas and BlueCross BlueShield of Texas services.